SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Filing at a Glance

Company: Boston Mutual Life Insurance Company

Product Name: Accident Policy	SERFF Tr Num: BSTN-125902180	State: ArkansasLH
TOI: H02I Individual Health - Accident Only	SERFF Status: Closed	State Tr Num: 40896
Sub-TOI: H02I.000 Health - Accident Only	Co Tr Num: IND-08-005	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Peggy Schwartz, Karen Thurston	Disposition Date: 11/24/2008
	Date Submitted: 11/20/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Worksite Accident Only Policy Revision

Project Number: IND-08-005

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/24/2008

State Status Changed: 11/24/2008

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed concurrently in the Commonwealth of Massachusetts.

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Filing Description:

Enclosed for your approval is a filing package for accident policy form WS-ACC 8/08 and its supporting documents. This policy package is substantially similar to and replaces policy package WIND-ACC 11/05 which was approved in your jurisdiction. A list showing the approval information for the replaced policy for each jurisdiction as well as a marked sample policy and a summary of the upgrades and/or changes is included in this filing.

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
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TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

The policy is an individual accident only product. Benefits are detailed in the policy and outlined in the Outline of Coverage. This individual policy is marketed in the employer/employee salary deduction market and the employer chooses the benefits that will be offered at that worksite. They may choose either a full accident coverage policy or a non-occupational accident coverage policy to limit over-insurance in occupational accident coverage due to worker's compensation coverage.

Seven optional riders are included in the filing for use with this policy:

SpAcc Rider 8/08 will be issued if the applicant elects coverage for a spouse.
CA-Rider 8/08 will be issued if the applicant elects coverage for a dependent child.
EPO-Rider 8/08 provides additional coverage for treatment of a covered accident in a physician's office.
EER-Rider 8/08 provides additional coverage for treatment of a covered accident in the emergency room.
WB-Rider 8/08 provides a flat benefit for certain health screening tests performed by a physician.
OHIV-Rider 8/08 provides an additional benefit if the insured person tests positive for HIV as the result of accidental exposure during the course of their occupation.
SH-Rider 8/08 provides a daily benefit amount if the insured person is confined to a hospital as the result of a covered sickness.

Coverage will be applied for using the application included in this filing. We are submitting two application versions for review. One (WSApp-P 8/08) is the hard copy/lap top version. This is the only version which is used during enrollment. This policy can be applied for at the applicant's worksite using an electronic lap top application. The information from the lap top application is given a unique security code and stored and transmitted to the home office on disk. When this electronic enrollment is processed, application (WSApp-E 8/08) is the print-out version of the application. This print-out of the electronic enrollment application is attached to the issued contract and stored in the company's files. A complete description of the electronic enrollment process is included under supporting documentation.

This accident coverage will be marketed through licensed agents and brokers in the general individual employer/employee worksite salary deduction market. These forms do not contain any unusual or controversial items from normal company standards and are in compliance with the laws and regulations of your state.

The forms are written in readable language that meets your minimum Flesch score requirements. A certification of readability is enclosed in this filing.

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

These forms have been filed concurrently in our state of domicile, Massachusetts.

Company and Contact

Filing Contact Information

Karen Thurston, Legal/Compliance Analyst
Compliance Dept
Canton, MA 02021

karen_thurston@bostonmutual.com
(781) 770-0430 [Phone]
(781) 770-0490[FAX]

Filing Company Information

Boston Mutual Life Insurance Company
120 Royall Street
Canton, MA 02021
(781) 770-0423 ext. [Phone]

CoCode: 61476
Group Code: 581
Group Name:
FEIN Number: 04-1106240

State of Domicile: Massachusetts
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$225.00
Retaliatory?	Yes
Fee Explanation:	Commonwealth of Massachusetts charges $150.00 to file rates and $75. for a form package. $150. + $75. = $225.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Boston Mutual Life Insurance Company	$225.00	11/20/2008	24058678

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/24/2008	11/24/2008

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Disposition

Disposition Date: 11/24/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Flesch Score Certification	Approved-Closed	Yes
Supporting Document	Prior approval for replaced forms	Approved-Closed	Yes
Supporting Document	Variability statement	Approved-Closed	Yes
Supporting Document	Electronic process explanation	Approved-Closed	Yes
Supporting Document	sample policy with changes highlighted	Approved-Closed	Yes
Supporting Document	Summary of enhancements	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Accident Policy	Approved-Closed	Yes
Form	Spouse Accident Rider	Approved-Closed	Yes
Form	Dependent Child Accident Rider	Approved-Closed	Yes
Form	Enhanced Emergency Room Rider	Approved-Closed	Yes
Form	Wellness Benefit Rider	Approved-Closed	Yes
Form	Enhanced Physician's Office/Urgent Care Rider	Approved-Closed	Yes
Form	Occupational HIV Benefit Rider	Approved-Closed	Yes
Form	Sickness Hospital Rider	Approved-Closed	Yes
Form	Worksite Accident Application - paper/lap top version	Approved-Closed	Yes
Form	Worksite Accident Application - Lap top print-out version	Approved-Closed	Yes
Rate	actuarial justification	Approved-Closed	No

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Form Schedule

Lead Form Number: WS-ACC 8/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	WS-ACC 8/08	Policy/Contract/Fraternal Certificate	Accident Policy	Initial		51	AccWSpolicyArkansas.pdf
Approved-Closed	SpAcc-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Spouse Accident Rider	Initial		50	SpAcc-Rider Revised 09232008 RFD.pdf
Approved-Closed	CA-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Dependent Child Accident Rider	Initial		52	AccWSCAriderArkansas.pdf
Approved-Closed	EER-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enhanced Emergency Room Rider	Initial		52	ERR-Rider Revised 09232008 RFD.pdf
Approved-	WB-Rider	Policy/Cont	Wellness Benefit	Initial		52	New WB

Closed	8/08	ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Rider			Rider Revised 09232008 RFD.pdf
Approved-Closed	EPO-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enhanced Physician's Office/Urgent Care Rider	Initial	57	EPO-Rider Revised 09232008 RFD.pdf
Approved-Closed	OHIV-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Occupational HIV Benefit Rider	Initial	52	OHIV-Rider Revised 09232008 RFD.pdf
Approved-Closed	SH-Rider 8/08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Sickness Hospital Rider	Initial	52	SH-Rider Revised RFD 09232008 RFD.pdf
Approved-Closed	NB1-WAP-P 8/08	Application/Enrollment Form	Worksite Accident Application - paper/lap top version	Initial	56	230-060 Stnd.pdf

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
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Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Approved-Closed	NB1-WAP-E 8/08	Application/Enrollment Form	Worksite Accident Application - Lap top print-out version	Initial		56	NB1WAP-E 08-08 std.pdf

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

ACCIDENT POLICY
GUARANTEED RENEWABLE FOR LIFE
[NON-OCCUPATIONAL]

THIS IS AN ACCIDENT ONLY POLICY. IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE
PLEASE READ IT CAREFULLY.

The premium You paid and the application You completed put this Policy in force as of the Policy Effective Date. The Policy Effective Date is shown on the Policy Specification Page (Page 3). A copy of Your application is attached.

PART A IMPORTANT PLEASE READ

Your application is a part of the Policy. PLEASE READ the copy of Your application. If anything in it is not correct You should tell Us. Your Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid. No associate (duly licensed agent) may change this Policy or waive any of its provisions.

PART B 30 DAY RIGHT TO EXAMINE POLICY

It is important to Us that You are satisfied with this Policy. If You are not satisfied, send it back to Us within 30 days after You have received it. We will send back Your money and the Policy will be considered to have never been in force.

PART C RENEWAL AGREEMENT

We will renew Your Policy each time You send Us the premium. It must be paid on or before the date it is due or during the 31 days that follow. Your Policy stays in force during this time unless You have requested termination of this Policy. Benefits and Policy provisions will be administered based upon the laws of the state where this Policy is issued.

PART D PREMIUM CHANGE

We may change the premium rates for this Policy. We can only change the premium if We change it for all Policies like Yours in Your class and in the same state where Your Policy was issued. "Class" means any group of persons insured individually under this Policy who have a common bond, such as, but not limited to: age, sex, occupation, premium payment method or geographical area.

Any change in premium will be explained to You in writing 31 days or more before the change is effective. We will write You at the address on Our records. Please notify Us of any change in address so Our records are updated.

<u>THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.</u> If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

-TABLE OF CONTENTS-

WHERE TO FIND IT

PART **PAGE**

POLICY SPECIFICATION PAGE

BENEFICIARY - AS DESIGNATED IN THE APPLICATION SUBJECT TO THE PROVISIONS OF THE POLICY.

***** THE PREMIUMS ARE DUE [TWELVE] TIMES A YEAR STARTING FROM THE DATE OF ISSUE****

SCHEDULE OF BENEFITS BENEFIT	AMOUNT	SCHEDULE OF PREMIUMS PAYABLE FOR	
BASIC POLICY BENEFITS		[$180.57	LIFE]
AMOUNT OF COVERAGE:	$ 50,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$100,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$100,000		
AMOUNT OF COVERAGE ON OR AFTER AGE 70	$ 50,000		
[SPOUSE ACCIDENT BENEFIT		$ 90.28	LIFE]
INSURED SPOUSE: JOHN DOE			
AMOUNT OF COVERAGE:	$ 50,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$100,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$100,000		
AMOUNT OF COVERAGE ON OR AFTER AGE 70	$ 50,000		
[DEPENDENT CHILDREN BENEFIT		$148.57	LIFE]
AMOUNT OF COVERAGE:	$ 10,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$ 20,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$ 50,000		
[ENHANCED EMERGENCY ROOM BENEFIT RIDER		$157.68	LIFE]
AMOUNT OF COVERAGE: [$300]			
[WELLNESS BENEFIT RIDER		$ 45.70	LIFE]
AMOUNT OF COVERAGE $50 PER CAL YR			
[SICKNESS-HOSPITAL CONFINEMENT BENEFIT RIDER		$ 91.41	LIFE]
AMOUNT OF COVERAGE $100 PER DAY			
[ENHANCED PHYSICIAN OFFICE / URGENT CARE TREATMENT BENEFIT RIDER		$ 51.42	LIFE]
AMOUNT OF COVERAGE: [$50]			
[OCCUPATIONAL HIV BENEFIT RIDER		$114.20	LIFE]
AMOUNT OF COVERAGE: [$50,000]			
TOTAL ANNUAL PREMIUM (AT ISSUE)		[$879.83]	

PREMIUMS IF PAID:

	ONCE A YEAR	TWICE A YEAR	FOUR TIMES A YEAR	MONTHLY SPECIAL BILL
	[$879.83	$453.12	$228.76	$ 76.99]
PER YEAR	[$879.83	$906.24	$915.04	$923.88]

****

ACCIDENT POLICY
GUARANTEED RENEWABLE FOR LIFE

****

PRIMARY INSURED [JANE DOE] [123456] POLICY NUMBER
OWNER [JANE DOE] DATE OF ISSUE [JAN 1, 2008]
[FAMILY] TYPE OF COVERAGE ISSUE AGE[35 FEMALE]

PART E DEFINITIONS

When We use the following words, this is what We mean:

"Calendar Year" means the period of time that begins on January 1 and ends on December 31, of the same year.

"Catastrophic Loss" means an Injury that within 365 days of the Covered Accident results in total and irrecoverable: (a) loss of both hands or both feet; or (b) loss or loss of use of both arms or both legs; or (c) loss of one hand or one foot; or (d) loss or loss of use of one arm or one leg; or (e) loss of the sight of both eyes; or (f) loss of the hearing in both ears; or (g) loss of the ability to speak.

The "loss of use of an arm" means the loss of function of the entire arm from the shoulder to the hand. The "loss of use of a leg" means the loss of function of the entire leg from the hip to the foot. The "loss of sight" means both eyes are totally blind and that no sight can be restored. The "loss of hearing" means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. The "loss of the ability to speak" means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

"Common Carrier" means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered vehicles are not Common Carriers.

"Confined" or "Confinement" means the assignment to a bed as a resident inpatient in a Hospital on the advice of a Physician or Confinement in an Observation Unit within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

"Controlled Substance" is a drug classified as such by the Drug Enforcement Administration of the Department of Justice.

"Covered Accident" is an Injury which: (a) occurs after the Policy Effective Date; (b) occurs while this Policy is in force; and (c) is not excluded by name or specific description in this Policy. [A Covered Accident does not include any Injury which occurs while the Insured Person is working for pay or profit].

"Emergency Room" is a specified area within a Hospital that is designated for the emergency care of accidental injuries. This area must: (a) be staffed and equipped to handle trauma; (b) be supervised and provide treatment by Physicians; and (c) provide care seven days per week, 24 hours per day. An Urgent Care Facility is not considered an Emergency Room.

"Hospital" means a primary care Hospital operated pursuant to law. The Hospital has organized facilities to provide first level treatment of sick and injured persons on an inpatient basis for which a charge is made. Organized facilities include emergency services, admissions services, clinical laboratory, diagnostic X-ray and an operating room.

Treatment facilities for emergency, medical and surgical services must be provided within the Hospital. The Hospital must provide 24 hour nursing services by or under the supervision of an R.N. (graduate registered Nurse), and be supervised by a staff of one or more Physicians. The Hospital also maintains on its premises the patient's written history and medical records.

Not included is a Hospital or institution or part of such Hospital or institution which is licensed or used principally as: (a) a hospice unit (including any beds designated as a hospice bed); (b) a swing bed; (c) a convalescent home; (d) a rest or nursing facility; (e) a skilled nursing facility; (f) a psychiatric unit; (g) a rehabilitation unit or facility; or (h) a facility primarily affording custodial care, educational care or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, drug addicts or alcoholics.

"Hospital Intensive Care Unit" means a place which: (a) is a specifically designated area of the Hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement; (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; (d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and (e) has a Physician assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care Unit is not any of the following step down units: (a) a progressive care unit; (b) an intermediate care unit; (c) a private monitored room; (d) sub-acute intensive care unit; (e) an Observation Unit; or (f) any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this Policy.

"Hospital Sub-Acute Intensive Care Unit" means a place which: (a) is a specifically designated area of the *hospital* that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward; (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement; (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and (d) is under constant and continuous observation by a specially trained nursing staff.
A Hospital Sub-Acute Intensive Care Unit may be referred to by other names such as progressive care, intermediate care, or a step-down unit, but it is not a regular private or semi-private room, or ward with or without monitoring equipment.

"Immediate Family" means the spouse, father, mother, sons, daughters, brothers or sisters of any Insured Person.

"Injury" means bodily harm caused by external and unexpected means and not contributed to by any other cause.

All injuries sustained in any one accident and all complications and re-occurrences of complications are considered to be a single Injury.

"Insured Person" means You and, if covered under an optional attached Rider, Your spouse and/or a dependent child.

"Mental or Emotional Disorder" means all conditions classified as mental disorders by the International Classification of Diseases including, but not limited to, psychoses, neurotic disorders, personality disorders, non-psychotic mental disorders or mental retardation whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement.

"Observation Unit" is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient surgery or treatment in the Emergency Room by a Physician and which: (a) is under the direct supervision of a Physician or registered nurse; (b) is staffed by nurses assigned specifically to that unit; and (c) provides care seven days per week, 24 hours per day.

"Physical Therapist" is a person, other than You or an Immediate Family member, who: (a) is licensed by the state to practice physical therapy; (b) performs services which are allowed by his license; (c) performs services for which benefits are provided by this Policy; and (d) practices according to the Code of Ethics of the American Physical Therapy Association.

"Physician" means a doctor of medicine or an osteopath who is duly licensed by the state medical board. Such person must not be the Primary Insured or any Insured Person's Immediate Family member and must be providing services within the scope of his or her license. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible physicians.

PART E DEFINITIONS CONTINUED

"Policy Effective Date" means the date on which this coverage shall begin. Coverage begins at 11:59 P.M. on the date the application is signed by You, provided the Company has approved the coverage applied for and has received the necessary policy premiums.

"Primary Insured" means the person named as the Primary Insured on the Policy Specification Page (Page 3).

"Rehabilitation Unit" means a designated area of a hospital or a free-standing facility which is not part of a hospital, which provides physical, occupational or speech therapy on a short term basis.

"Urgent Care Facility" means a free-standing facility, which is not part of a Hospital, or Hospital Emergency Room, which provides care on an urgent basis.

"We", "Our" or "Us" means Boston Mutual Life Insurance Company.

"You" ***or*** **"Your"** means the person named as the Primary Insured on the Policy Specification Page (Page 3). You are insured for the benefits of the Policy as of the Policy Effective Date.

PART F EXCLUSIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for losses that are caused by or are the result of any Insured Person:

(1) practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
(2) having any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury;
(3) intentionally self-inflicted Injury;
(4) committing suicide or attempted suicide, while sane or insane;
(5) receiving injuries due to an act of declared or undeclared war;
(6) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or any Military Reserve;
(7) driving any taxi for wage, compensation, or profit;
(8) having Mental or Emotional Disorders;
(9) suffering from alcoholism or drug addiction;
(10) suffering from a loss sustained or contracted as the result of being physically or mentally impaired due to being under the influence of alcohol or any illicit or Controlled Substance unless administered on the advice of a Physician; "Being under the influence of alcohol", for purposes of this Policy, means a blood alcohol level of 0.08 or more. The Insured Person's alcohol or illicit or Controlled Substance impairment must be the cause or contributing cause of his or her loss, irrespective of whether the loss occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
(11) sustaining a loss to which a contributing cause was the commission of or an attempt to commit a felony. Nor will We be liable for any loss to which a contributing cause was being engaged in an illegal activity.

[(12) incurring an injury while the Insured Person is working for pay or profit.]

PART G BENEFITS

This policy will pay the following benefits for loss resulting from a Covered Accident:

ACCIDENTAL DEATH: The benefit amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident, and the Injury causes any Insured Person to die within 90 days after the Covered Accident.

ACCIDENTAL DEATH-COMMON CARRIER: The benefit amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident while a fare paying passenger on a Common Carrier and the Injury causes any Insured Person to die within 90 days after the Covered Accident. If We pay this benefit, We will not pay the Accidental Death benefit.

ACCIDENT FOLLOW-UP TREATMENT: $50 if any Insured Person receives follow-up treatment that is recommended or advised by a Physician for injuries received as the result of a Covered Accident. Follow-up treatment must:

(1) be within 90 days of the Covered Accident;
(2) occur after initial treatment in a Physician's office or Emergency Room; and
(3) not be for routine examinations or preventive testing.

We will pay this amount once per Covered Accident.

AIR AMBULANCE: $500 if a licensed professional air ambulance company transports by air any Insured Person to or from a Hospital or between medical facilities, where treatment for injuries is received as the result of a Covered Accident. The air ambulance transportation must be within 48 hours after the Covered Accident. We will pay this amount once per Covered Accident.

AMBULANCE: $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for injuries is received as the result of a Covered Accident. The ambulance transportation must be within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

APPLIANCE: $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches and wheelchairs are examples of medical appliances. The use of an appliance must begin within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

BLOOD/PLASMA/PLATELETS: $300 if any Insured Person is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma and platelets as the result of the Injury. The blood, blood plasma and platelets must be administered within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

BURN: The applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

Second degree burns which cover at least 36% of the body surface	$ 750
Third degree burns which cover at least nine square inches of the body surface but less than 35 square inches	$ 1,500
Third degree burns which cover 35 or more square inches of the body surface	$10,000

CATASTROPHIC ACCIDENT: The applicable benefit amount shown on the Policy Specification Page (Page 3) at the end of the elimination period if any Insured Person:
(1) sustains a Catastrophic Loss as the result of a Covered Accident;
(2) is under the appropriate care of a Physician during the elimination period; and
(3) remains alive at the end of the elimination period.

The Catastrophic Accident benefit will be payable once per lifetime for any Insured Person. This benefit reduces by 50% at age 70.

"Elimination Period" means the period of 365 days after the date of a Covered Accident.

CONCUSSION: $100 if any Insured Person sustains a concussion as the result of a Covered Accident and is diagnosed by a Physician within 72 hours from the date of the Covered Accident using any type of medical imaging procedure such as an X-ray, CT (computerized tomography) scan and/or MRI (magnetic resonance imaging). We will pay this amount once per Covered Accident. We will not pay the Concussion benefit if the Major Diagnostic Exams benefit is payable for the same Covered Accident.

DISLOCATION (SEPARATED JOINT): The applicable amount listed if any Insured Person receives a dislocation as the result of a Covered Accident. A dislocation is a completely separated joint. In order for this benefit to be payable for the joint involved, all of the following must occur:
(1) it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;
(2) the dislocation must require correction with anesthesia by a Physician; and
(3) it can be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident, and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

If any Insured Person receives a fracture and a dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

We will pay this benefit only for the first dislocation of a joint after the Policy Effective Date. Subsequent dislocations of the same joint after the Policy Effective Date will not be covered.

JOINT	**CLOSED REDUCTION**	**OPEN REDUCTION**
Hip	$4,000	$8,000
Knee (except Patella)	$2,000	$4,000
Ankle – Bone or Bones of the Foot (other than Toes)	$1,600	$3,200
Collarbone (Sternoclavicular)	$1,000	$2,000
Lower Jaw	$ 600	$1,200
Shoulder (Glenohumeral)	$ 600	$1,200
Elbow	$ 600	$1,200
Wrist	$ 600	$1,200
Bone or Bones of the Hand (other than Fingers)	$ 600	$1,200
Collarbone (Acromioclavicular and separation)	$ 200	$ 400
One Toe or Finger	$ 200	$ 400

EMERGENCY DENTAL WORK: The applicable amount listed below for dental work required by any Insured Person as the result of injuries received in a Covered Accident.

Broken teeth repaired with crown(s) $150
Broken teeth resulting in extraction(s) $ 50
Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

EMERGENCY ROOM TREATMENT: $50 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in a Hospital Emergency Room within 72 hours after the Covered Accident. We will pay this amount once per Covered Accident.

Follow-up treatment prescribed by a Physician will be paid under the Accident Follow-Up Treatment benefit.

EYE INJURY: $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. We will pay this amount once per Covered Accident. An examination with anesthesia will not be considered surgery.

FRACTURE (BROKEN BONE): The applicable amount listed if any Insured Person receives a fracture as the result of a Covered Accident. A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

(1) it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and
(2) the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

If any Insured Person receives more than one fracture in a Covered Accident, and he requires open or closed reduction, We will pay for all fractures. However, We will pay no more than two times the amount for the bone involved which has the highest benefit amount. If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

If any Insured Person receives a fracture and a dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

FRACTURE (BROKEN BONE) Continued

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

BONE	CLOSED REDUCTION	OPEN REDUCTION
Skull (except Bones of Face or Nose)		
Depressed Skull Fracture	$5,000	$10,000
Skull (except Bones of Face or Nose)		
Simple Non-depressed Skull Fracture	$2,000	$4,000
Hip, Thigh (Femur)	$3,000	$6,000
Vertebrae, Body of (excluding Vertebral Processes)	$1,600	$3,200
Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)	$1,600	$3,200
Leg (Tibia and/or Fibula)	$1,600	$3,200
Bones of Face or Nose (except Mandible or Maxilla)	$ 700	$1,400
Upper Jaw, Maxilla (except Alveolar Process)	$ 700	$1,400
Upper Arm between Elbow and Shoulder (Humerus)	$ 700	$1,400
Lower Jaw, Mandible (except Alveolar Process)	$ 600	$1,200
Shoulder Blade (Scapula), Collarbone (Clavicle, Sternum)	$ 600	$1,200
Vertebral Processes	$ 600	$1,200
Forearm (Radius and/or Ulna), Hand, Wrist (except Fingers)	$ 600	$1,200
Kneecap (Patella)	$ 600	$1,200
Foot (except Toes)	$ 600	$1,200
Ankle	$ 600	$1,200
Rib	$ 500	$1,000
Coccyx	$ 400	$ 800
Finger, Toe	$ 100	$ 200

HOSPITAL ADMISSION: $1,000 per admission ($2,000 if immediately admitted to an Intensive Care Unit) if any Insured Person is Confined to a Hospital as the result of injuries received in a Covered Accident. The Insured Person must be Confined within six months after the Covered Accident. We will not pay this benefit for:

(1) Emergency Room treatment;
(2) outpatient treatment, or
(3) a stay of less than 20 hours in an Observation Unit.

We will pay this amount once per Covered Accident.

HOSPITAL CONFINEMENT: $250 per day for up to 365 days per Covered Accident if any Insured Person is Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit as the result of injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit within six months after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident.

We will not pay this benefit for:

(1) Emergency Room treatment;
(2) outpatient treatment, or
(3) a stay of less than 20 hours in an Observation Unit.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.

HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: $500 per day for up to 30 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a hospital intensive care unit that does not meet the definition in this Policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit. We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 30 days, the Hospital Confinement benefit will begin on the 31st day. The total amount payable per Covered Accident will not exceed 365 days for Hospital Confinement and 30 days for Hospital Intensive Care Unit Confinement.

KNEE CARTILAGE – TORN: $750 if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. In order for this benefit to be payable, all of the following must occur:
(1) it must be treated by a Physician within 60 days after the Covered Accident; and
(2) it must be repaired through surgery by a Physician within six months after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), We will pay a benefit of $150.

LACERATION: The applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay will be based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Laceration(s) treated without stitches, staples, glue	$ 25
Total of all lacerations is not more than three inches long (less than 7.6 centimeters) and repaired by stitches	$ 50
Total of all lacerations is greater than three and not more than five inches long (7.6 to 12.5 centimeters) and repaired by stitches	$200
Total of all lacerations is over five inches long (over 12.5 centimeters) and repaired by stitches	$400

If any Insured Person receives a laceration on a finger, toe, hand, foot, or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye benefit.

LODGING: $100 per night for one motel/hotel room for a companion to accompany any Insured Person for up to 30 days per Covered Accident. We will pay this benefit if any Insured Person is Confined in a Hospital as the result of a Covered Accident.

This benefit is payable only for motel/hotel stays during the period of time any Insured Person is Confined to the Hospital. In order for this benefit to be payable, the *hospital* must be more than 100 miles from the residence of the Insured Person.

LOSS OF FINGER, TOE, HAND, FOOT OR SIGHT OF AN EYE: The applicable amount listed below for any Insured Person for loss received as the result of a Covered Accident and which occurs within 90 days after the Covered Accident.

Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$30,000
Loss of one hand, or one foot, or sight of one eye	$15,000
Loss of two or more fingers, or two or more toes, or any combination of two or more listed above	$ 3,000
Loss of one finger or one toe	$ 1,500

"Loss of a hand" means that the hand is cut off through or above the wrist joint or the use of the hand is permanently lost. "Loss of a foot" means that the foot is cut off through or above the ankle joint or the use of the foot is permanently lost. "Loss of a finger" means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. "Loss of a toe" means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. "Loss of sight of an eye" means that at least 80% of vision is permanently lost.

If any Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount We paid for that loss of a finger or toe from the benefit We paid for the loss of a hand or foot.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death benefit will be paid.

MAJOR DIAGNOSTIC EXAMS: $150 per Calendar Year if any Insured Person requires one of the following exams for injuries received as the result of a Covered Accident:

(1) CT (computerized tomography) scan;
(2) MRI (magnetic resonance imaging); or
(3) EEG (electroencephalogram).

These exams must be performed in a Hospital, or a Physician's office.
We will not pay the Concussion benefit if the Major Diagnostic Exams benefit is payable for the same Covered Accident.

PHYSICAL THERAPY: $25 per day for each day any Insured Person requires physical therapy treatment as the result of a Covered Accident. We will pay a maximum of six days per Covered Accident. The therapy must begin within 60 days after the Covered Accident and must be completed within six months after the Covered Accident. All services must be prescribed by a Physician and rendered by a Physical Therapist and performed in an office or in a Hospital on an inpatient or outpatient basis.

This benefit is not payable for the same visit that the Accident Follow-Up Treatment benefit is paid.

PHYSICIAN'S OFFICE/URGENT CARE: $50 if any Insured Person receives initial treatment and/or advice by a Physician in a physician's office or Urgent Care Facility for injuries as the result of a Covered Accident. The treatment must be within 60 days of the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventive testing. We will pay this amount once per Covered Accident.
Follow-up treatment prescribed by a Physician will be paid under the Accident Follow-Up Treatment benefit.

PROSTHETIC DEVICE/ARTIFICIAL LIMB: The applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when any Insured Person loses a hand, foot or sight of an eye due to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. We will pay this amount once per Covered Accident.

One prosthetic device or artificial limb	$ 500
More than one device or artificial limb	$1,000

We will not pay this benefit for:
(1) hearing aids;
(2) dental aids, including false teeth;
(3) eye glasses;
(4) cosmetic prosthesis such as hair wigs; or
(5) joint replacement such as an artificial hip or knee.

REHABILIATION UNIT: $150 per day if any insured person is confined in a Rehabilitation Unit for physical, occupational or speech therapy treatment of covered injuries. The rehabilitation unit confinement must be preceded by confinement in a hospital. This benefit is limited to a maximum of 30 days per insured person per accident. The Rehabilitation Unit benefit will not be paid if the Hospital Confinement Benefit is paid for the same day; only the highest eligible benefit will be paid.

RUPTURED DISC: $400 if any Insured Person receives a ruptured disc in his spine as the result of a Covered Accident. In order for this benefit to be payable, all of the following must occur:
(1) it must be treated by a Physician within 60 days after the Covered Accident; and
(2) it must be repaired through surgery by a Physician within one year after the Covered Accident.
We will pay this amount once per Covered Accident.

SKIN GRAFTS: We will pay 25% of the applicable Burn benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn benefit of this Policy. This benefit will be payable only once per Covered Accident.

SURGERY: $1,000 if any Insured Person undergoes open abdominal or thoracic surgery within 72 hours of the Covered Accident to repair internal injuries received as a result of a Covered Accident. For open abdominal or thoracic exploratory surgery without repair or other open abdominal or thoracic surgery without repair, We will pay a benefit of $100. We will pay this amount once per Covered Accident. Hernia repair will not be covered under this benefit.

TENDON/LIGAMENT/ROTATOR CUFF: The applicable amount listed below if any Insured Person receives an injured tendon/ligament/rotator cuff as the result of a Covered Accident. It must be torn, ruptured or severed. It must be repaired through surgery by a Physician within 90 days after the Covered Accident.

Repair of one tendon, ligament or rotator cuff	$600
Repair of more than one of the above	$900

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $150.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

TRANSPORTATION: $300 per round trip if any Insured Person must travel more than 100 miles round trip to receive special treatment and Confinement in a Hospital for injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

PART H HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after loss covered by this Policy occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received by Us at:

[Philadelphia American Life Insurance Company
Claims Administrator for Boston Mutual Life
P. O. Box 34952
Omaha NE 68134-9632]

or to Our Home Office in Canton, Massachusetts. It should include Your name and Policy number as shown on the Policy Specification Page (Page 3).

CLAIM FORMS: When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

PROOF OF LOSS: Written proof of loss, except for Catastrophic Accident, must be given to Us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PROOF OF LOSS FOR CATASTROPHIC ACCIDENT: Written proof of loss must be given to Us within 90 days after the Catastrophic Accident elimination period ends. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PART I TIME PAYMENT OF CLAIMS

Benefits for any loss covered by this Policy will be paid immediately upon receipt by Us of proper written proof.

PART J PAYMENT OF CLAIMS

All benefits will be paid to You or Your estate. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

Any accidental death benefits payable as the result of Your death will be paid to Your beneficiary. Your beneficiary is the person You named in the application as Your beneficiary, unless it was changed at a later date. If You did not name a beneficiary or if the person You named is not living at Your death, any accidental death benefits due will be paid in this order to: (a) Your spouse; (b) Your children; (c) Your parents; (d) Your brothers or sisters; (e) Your estate.

PART K GENERAL INFORMATION

ENTIRE CONTRACT; CHANGES: This Policy is a legal contract between You and Us. The entire contract consists of the Policy, which includes the application, and any attached papers. No change in this Policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date a person becomes covered under this Policy We cannot use misstatements, except fraudulent misstatements, in Your application to void coverage or deny a claim for loss that happens after the two year period.

The above provisions also apply to riders attached to this Policy. In applying them the word "Rider" will be used for the word "Policy".

LEGAL ACTIONS: You cannot bring a legal action to recover benefits under Your Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

GRACE PERIOD: Your premium must be paid on or before the date it is due or during the 31 day grace period that follows. The Policy stays in force during Your Grace Period. This grace period does not apply if You request termination of this Policy.

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and We accept a premium without requiring an application for reinstatement, that payment shall reinstate this Policy. If We require an application, this Policy will be reinstated when We approve it. If We do not approve the application, this Policy will be reinstated on the 45th day after the date of the application unless We notify You in writing of its disapproval.
After two years from the date We reinstate this Policy, We cannot use misstatements in Your reinstatement application to void coverage or deny a claim for loss that happens after the two-year period. In all other respects You and We have the same rights under this Policy as We both had before it lapsed, unless special conditions are added to this Policy in connection with the reinstatement. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

MISSTATEMENT OF AGE: If the Insured's Age or sex has not been stated correctly, an adjustment in premium, coverage, or both, will be made. The adjustment will correct the coverage to what the premium paid would have bought at the Insured Person's true Age and sex. This change will be based on our rates in effect on the Date of Issue.

OTHER INSURANCE WITH US: If You have more than one Accident Policy with Us, only one Policy chosen by You will be effective (this includes coverage for any Insured Person). We will cancel the Policy and refund all premiums paid for all other policies in force during the same period of time.

CHANGE OF BENEFICIARY: The beneficiary is named in the application or later endorsement as it applies to the Accidental Death benefit. The Primary Insured is the beneficiary for the spouse and children if these optional riders are included. You may change the beneficiary by written request without their consent. This change will take effect when We receive it. A payment by Us prior to receipt of such change will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have any Insured Person examined when and as often as is reasonable during the handling of a claim and do an autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at our expense.

ILLEGAL OCCUPATION: We will not be liable for any loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or to which a contributing cause was the Insured Person's being engaged in an illegal occupation.

INTOXICANTS AND NARCOTICS: We will not be liable for any loss sustained or contracted as the result of an Insured Person being physically or mentally impaired due to being under the influence of alcohol or any illicit or controlled substance unless administered on the advice of a Physician. "Being under the influence of alcohol" for purposes of this Policy, means a blood alcohol level of 0.08 or more. The Insured Person's alcohol or illicit or controlled substance impairment must be the cause or contributing cause of his or her loss, irrespective of whether the loss occurred while the Insured Person was driving a motor vehicle or engaged in any other activity.

PART K GENERAL INFORMATION CONTINUED

TERM OF COVERAGE: Coverage starts on the Policy Effective Date at 11:59 p.m., Standard Time where You live. It ends at 12:01 a.m. on the same Standard Time on the renewal date, subject to the grace period. This Policy may be renewed only as stated in the Renewal Agreement. Each time this Policy is renewed, the new term begins when the old term ends.

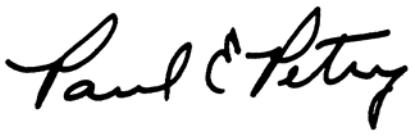
REFUND OF PREMIUM: On the death of the Insured Person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the Policy month in which the death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the Insured Person' death has been furnished to Us.

CHARTER AND BY-LAWS: No provisions of Our charter and by-laws not included in this Policy shall void this Policy or be used in defense of any legal proceedings with regard to it.

NOTICE OF ANNUAL MEETING: You are welcome to come to Our Annual Meeting. It is held on the third Wednesday in April at three o'clock in the afternoon at Our Home Office in Canton, Massachusetts. You are entitled to one vote during the Annual Meeting.

POLICY SPECIFICATION PAGE: The Policy Specification Page (Page 3) and information it shows is a part of the Policy.

Signed for Us at Our Home Office on the Policy Effective Date.



President

Secretary

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

SPOUSE ACCIDENT INSURANCE RIDER

We, Our or Us means Boston Mutual Insurance Company. **You or Your** means the Spouse of the Primary Insured named on the Policy Specification Page (Page 3) of the Policy to which this Rider is attached.

The premium the Primary Insured paid and the application the Primary Insured completed has put this Rider in force as of the Rider Effective Date. A copy of the application is attached. This Rider is made part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in the Rider. As a covered spouse, you are an Insured Person under this Rider.

DEFINITIONS

The definitions shown in the Policy apply to this Rider. In applying them, substitute "Rider" for "Policy". Defined terms are capitalized whenever they appear in the Rider.

The following definitions are added to this Rider:

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

"Spouse" shall mean the person recognized as the Primary Insured's husband or wife under the laws of the state where the Primary Insured resides on the effective date of this rider. To qualify for coverage, the spouse must be:

1. named in the application;
2. accepted for coverage under the Rider; and
3. named on the Policy Specification Page or on a Policy Specification Page endorsement.

BENEFITS

The benefits shown in the Policy apply to this Rider. In applying them, substitute "Rider" for "Policy".

EXCLUSIONS

The exclusions shown in the Policy apply to this Rider. In applying them, substitute "Rider" for "Policy".

TERMINATION OF COVERAGE

This Rider will terminate on the earliest of:

1. when the Policy terminates;
2. the date We receive the Primary Insured's written request to cancel the Rider (in which case the grace period will not apply);
3. the date of the Spouse's death
4. In the event of divorce between the Primary Insured and Spouse, coverage will terminate 30 days from the date we receive actual written notice from the Primary Insured or Spouse of the divorce, regardless of the date of your divorce decree.

In the event of cancellation or death, We will promptly return the unearned portion of any premium paid under this Rider. Termination of coverage will not affect any claim for benefits for a loss incurred while this Rider is in force.

RIDER PROVISIONS

The Time Limit On Certain Defenses and Reinstatement provision contained in the Policy are deleted and replaced by the following for the purposes of this Rider only.

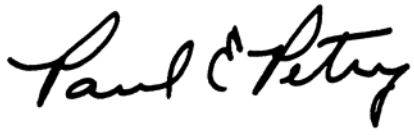
Time Limit On Certain Defenses: After two years from the date a Spouse becomes covered under this Rider, We cannot use misstatements, except fraudulent misstatements in the application, to void coverage or deny a claim for loss incurred after the two year period.

After two years following the date of reinstatement of a Spouse's coverage under this Rider, We cannot use misstatements, except fraudulent misstatements in the application, to void coverage or deny a claim for loss incurred after the two year period.

Reinstatement: This Rider will lapse if the premium for the Rider and the Policy to which it is attached is not paid before the end of the grace period. If We later accept a premium and do not require an application for reinstatement, that payment will put this Rider back in force. If We require an application for reinstatement, this Rider will be put back in force when We approve the application. If We do not approve the application, this Rider will be put back in force on the 45th day following the date of the application if We do not give the Primary Insured prior written notice of its disapproval. In order for this Rider to be reinstated, the Policy to which it is attached must also qualify for reinstatement.

In all other respects the Primary Insured and Us have the same rights under this Rider as We both had before it lapsed. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

Signed for Us at Our Home Office on the Rider Effective Date.



President

Secretary

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

Boston Mutual Life Insurance Company

DEPENDENT CHILDREN ACCIDENT INSURANCE RIDER

We, Our or Us means Boston Mutual Insurance Company. **You or Your** means the Dependent Children or Dependent Child of the Primary Insured named on the Policy Specification Page (Page 3) of the Policy to which this Rider is attached.

The premium the Primary Insured paid and the application the Primary Insured completed has put this Rider in force as of the Rider Effective Date. A copy of the application is attached. This Rider is made part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in the Rider. This Rider insures all eligible dependents who meet the definition of Dependent Children or Dependent Child and are referred to in the policy as an Insured Person.

DEFINITIONS

The definitions shown in the Policy apply to this Rider. In applying them, substitute "Rider" for "Policy". Defined terms are capitalized whenever they appear in the Rider.

The following definitions are added to this Rider:

"Dependent Children or Dependent Child" means any natural children, step-children, legally adopted children or children placed into Your custody for adoption who are (a) unmarried; (b) living with You in a regular parent child relationship; (c) qualified as dependents of You or Your spouse for tax purposes according to the United States Internal Revenue Code; and (d) younger than age 21 (age 23 if a full-time student).

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

BENEFITS

The benefits shown in the policy apply to this Rider. In applying them, substitute "Rider" for "Policy".

EXCLUSIONS

The exclusions shown in the Policy apply to this Rider. In applying them, substitute "Rider" for "Policy".

DEPENDENT CHILDREN PROVISIONS

ELIGIBILITY

To be eligible for benefits under this Rider, a child must meet the definition of Dependent Children or Dependent Child.

Eligible dependents not insured on the Policy Effective Date may become Insured Persons, subject to acceptance by us of your written application and payment of any required premium. This written application only applies to the addition of the first Dependent Child.

NEWBORN CHILDREN AND ADOPTED CHILDREN

Any child of the Primary Insured born while this Rider is in force will be automatically insured from birth. Coverage for the newborn will continue in effect thereafter, without evidence of insurability, provided this Rider remains in force and the child meets the definition of a Dependent Child.

Any child placed with the Primary Insured for the purpose of adoption while this Rider is in force will be automatically insured from the moment of placement in the residence of the Primary Insured. Coverage will be provided to the same extent as for a natural newborn child born while this Rider is in force.

In case of adoption of a newborn infant born while this Rider is in force, automatic coverage will be effective from the moment of birth if:

1. a written agreement to adopt the child has been entered into by the Primary Insured prior to the birth of the child; and
2. the child is ultimately placed in the Primary Insured's residence.

TERMINATION OF COVERAGE

Coverage for the Dependent Children or Dependent Child will end on the earliest of the following:

1. when the Policy terminates;
2. the date We receive the Primary Insured's written request to cancel the Rider (in which case the grace period will not apply);
3. when the Dependent Children or Dependent Child does not qualify as a dependent of you or your spouse for tax purposes according to the United States Internal Revenue Code;
4. when the Dependent Children or Dependent Child reaches Age 21 (Age 23 if a full-time student); or
5. when the Dependent Children or Dependent Child gets married.

TERMINATION OF COVERAGE CONTINUED

If a child reaches the termination date stated above and continues to be both: (a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) chiefly dependent upon You for support and maintenance, and You notify Us about this, coverage for such child will continue while the Policy is in force and so long as such incapacity continues and the applicable premium is paid. We will continue to charge any appropriate premium for that child as long as he/she qualifies as a handicapped dependent.

Coverage for each Dependent Child will terminate as explained above. When the last child no longer qualifies as a Dependent Child, then the last child's coverage shall end and this rider will be terminated as of the first renewal date following the occurrence of the event and our liability is limited to a refund of any unearned premium for this rider.

It is the Primary Insured's responsibility to notify us when a Dependent Child no longer qualifies as a dependent according to the United States Internal Revenue Code, reaches age 21 (or age 23 if a full-time student) or is married.

We will promptly return the unearned portion of any premium paid. Termination of coverage will not affect any claim for benefits for a loss incurred while this rider is in force so long as the child meets the definition of a Dependent Child.

RIDER PROVISIONS

The Time Limit On Certain Defenses and Reinstatement provision contained in the Policy are deleted and replaced by the following for the purposes of this Rider only.

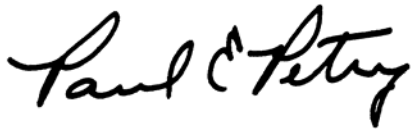
Time Limit On Certain Defenses: After two years from the date the Dependent Children or Dependent Child becomes covered under this Rider, We cannot use misstatements, except fraudulent misstatements in the application, to void coverage or deny a claim for loss incurred after the two year period.

After two years following the date of reinstatement of the Dependent Children or Dependent Child's coverage under this rider, We cannot use misstatements, except fraudulent misstatements in the application, to void coverage or deny a claim for loss incurred after the two year period.

Reinstatement: This Rider will lapse if the premium for the Rider and the Policy to which it is attached is not paid before the end of the grace period. If We later accept a premium and do not require an application for reinstatement, that payment will put this Rider back in force. If We require an application for reinstatement, this Rider will be put back in force when We approve the application. If We do not approve the application, this Rider will be put back in force on the 45th day following the date of the application if We do not give the Primary Insured prior written notice of its disapproval. In order for this Rider to be reinstated, the Policy to which it is attached must also qualify for reinstatement.

In all other respects the Primary Insured and Us have the same rights under this Rider as We both had before it lapsed. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

Signed for Us at Our Home Office on the Rider Effective Date.



President

Secretary

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

ENHANCED EMERGENCY ROOM BENEFIT RIDER

Boston Mutual Life Insurance Company (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS

We will pay the amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident and requires examination and treatment by a Physician in a Hospital Emergency Room within 72 hours after the Covered Accident. This benefit is paid in addition to the Emergency Room Treatment Benefit included in the base policy. We will pay this amount once per Covered Accident.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section.

The following definition is added to this Rider:

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

President **Secretary**

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

WELLNESS BENEFIT RIDER

Boston Mutual Life Insurance Company (herein called **We, Our or Us**) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS

We will pay the amount shown on the Policy Specification Page (Page 3) for any one of the following health screening tests listed below performed by a Physician more than 30 days after the Rider Effective Date. We will pay this benefit regardless of the results of the test. The benefit is payable only once per calendar year per Insured Person. A calendar year begins on January 1st and ends on December 31st. This benefit is not payable for health screening tests performed in the Emergency room of a hospital.

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- C-Reactive Protein
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Electron Beam Tomography
- Fasting blood glucose test
- Flexible Sigmoidoscopy
- Hemocult stool analysis
- Homocysteine Level
- Mammography
- PSA (blood test for prostate cancer)
- Pap Smear
- Serum cholesterol test to determine level of HDL/LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section.

The following definition is added to this Rider:

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

President **Secretary**

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

ENHANCED PHYSICIAN OFFICE/URGENT CARE TREATMENT BENEFIT RIDER

Boston Mutual Life Insurance Company (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS

We will pay the amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident and requires examination and treatment by a Physician in a physician's office or Urgent Care Facility. The treatment must be within 60 days of the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventative testing. We will pay this amount once per Covered Accident. Follow-up treatment prescribed by a Physician will be paid under the Accident Follow-Up Treatment benefit.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section.

The following definition is added to this Rider:

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

President **Secretary**

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

OCCUPATIONAL HIV BENEFIT RIDER

Boston Mutual Life Insurance Company (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS

We will pay the amount shown on the Policy Specification Page (Page 3) if any Insured Person is initially diagnosed as HIV Positive for Occupational HIV due to a Covered Injury while this Rider is in force. We will pay this amount once per Insured Person.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section.
The following definitions are added to this Rider:

"Covered Injury" means an accidental:

a. cutaneous exposure through abraded skin;
b. percutaneous exposure; or
c. mucocutaneous exposure

that occurs while the Insured Person is covered by this benefit, actively at work and performing all the regular duties of his or her occupation on a full-time basis.

"HIV" means human immunodeficiency virus.

"HIV Positive" means the presence of HIV antibodies in the blood of an Insured Person as substantiated through both a positive screening test enzyme-linked immunosorbent assay (ELISA), and a positive supplement test such as the Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positive results as specified by the manufacturer(s).

"Occupational HIV" means an Insured Person, as a direct result of a Covered Injury, tests HIV Positive, subject to the following:

a. an incident report (notice of exposure) on a form acceptable to Us, which describes the nature of the exposure to HIV, must be filed with the Insured Person's employer within 48 hours and be sent to Us as soon as soon as reasonably possible, after the accident;
b. the Insured Person must not have previously tested positive for HIV, or if he or she had previously tested positive for HIV, the Insured Person subsequently tested negative for HIV prior to the date of the accident;
c. the Insured Person must have a preliminary screening test, such as ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing), for HIV within 48 hours of the Injury at an authorized laboratory other than the laboratory of his or her employer. We must receive notification: 1) of the results of that test as soon as reasonably possible; and 2) that the results are negative; and thereafter, the Insured person must test HIV positive within 26 weeks of the date of the Injury reported in item a. above. We must receive notification of HIV Positive test results as soon as reasonably possible.

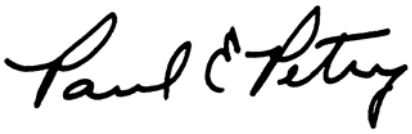
"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

EXCLUSIONS

The following Exclusions are added to this Rider:

1. No benefits will be paid for Occupational HIV resulting from a needle stick or sharp injury or a mucous membrane exposure to blood or blood-stained bodily fluid which occurred prior to the effective date of this Rider.
2. We will not pay for any cost incurred for HIV tests or any related testing or treatment.

Signed for Us at Our Home Office on the Rider Effective Date.



President

Secretary

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

SICKNESS - HOSPITAL CONFINEMENT BENEFIT RIDER

Boston Mutual Life Insurance Company (herein called **We, Our or Us**) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless *we* state otherwise in this Rider.

BENEFITS

We will pay the daily hospital confinement benefit shown on the Policy Specification Page (Page 3), for each day an Insured Person is Confined in a Hospital as the result of a Covered Sickness. This benefit is not payable concurrently with the Hospital Confinement Benefit or the Hospital Intensive Care Unit Confinement Benefit in the Policy.

Benefits are limited to 30 days for each period of Hospital Confinement. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Sickness. We will not pay this benefit for Emergency Room treatment, for outpatient treatment or for a stay of less than 20 hours in an Observation Unit.

If We pay this benefit for a Hospital Confinement and the Insured Person becomes Confined to a Hospital again within 90 days because of the same or related Covered Sickness, We will treat this Confinement as a continuation of the prior Confinement, subject to the 30 day maximum.

If more than 90 days have passed between the periods of Hospital Confinement, We will treat this Confinement as a new Confinement.

EXCLUSIONS AND LIMITATIONS

The Exclusions contained in the Policy apply to this Rider. In addition, the following apply to this Rider.

We will not pay benefits for a Hospital Confinement that is caused by or occurs as the result of the Insured Person(s)
(1) Injury;
(2) treatment for dental care or dental care procedures; or
(3) elective procedures and/or cosmetic surgery or reconstructive surgery unless it is a result of infection, or other diseases.
We will not pay for any Hospital Confinement of a newborn child following birth unless the child has a Covered Sickness.

Pre-Existing Conditions-Limitations For Certain Conditions: The benefits of this Rider will not be payable for any pre-existing conditions during the first 12 months this Rider is in force. After this 12-month period, however, We will pay benefits for any pre-existing condition not specifically excluded from coverage if the covered Confinement began more than 12 months after the Rider Effective Date. This 12-month period is measured from the Rider Effective Date for each Insured Person. A pre-existing condition means a sickness or physical condition for which an Insured Person was treated, received medical advice or had taken medication within 12 months before the Rider Effective Date.

DEFINITIONS

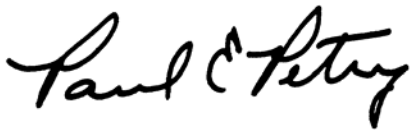
The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section. In addition, the following definition ap plies to this Rider.

"Covered Sickness" means an illness, infection, disease or any other abnormal physical condition which is not caused by an Injury and:

(a) occurs after the Rider Effective Date;
(b) occurs while this Rider is inforce;
(c) is not excluded by name or specific description in this Rider.

"Rider Effective Date" means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by the Primary Insured requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.



President

Secretary

NEW ☐ ADD ☐

BOSTON MUTUAL LIFE INSURANCE COMPANY

ACCIDENT INSURANCE APPLICATION

120 Royall Street
Canton, MA 02021

PART A:

1. Proposed Insured *(Employee)*				2. Gender ☐ M ☐ F	7. Proposed Insured *(Spouse)*			8. Gender ☐ M ☐ F
3. Date of Birth	4. Age	5. Place of Birth State	6. Phone No. ( )		9. Date of Birth			10. Age

11. Present Residence

No. Street City State Zip

12. Mailing Address *(if different)*

13. S.S. No. *(Employee)*

14. Are you actively at work? ☐ YES ☐ NO

15. Plan *(select one)*

☐ Employee Only-*Weekly Premium* [ ]
☐ Employee/Spouse-*Weekly Premium* [ ]
☐ Employee/Children-*Weekly Premium* [ ]
☐ Employee/Spouse/Children-*Weekly Premium* [ ]

16. Additional Riders:

☐ Wellness Benefit Rider . . . . . .
☐ Sickness-Hospital Confinement Benefit Rider *(complete Part B)* . . . . . .
☐ Enhanced Emergency Room Benefit Rider *($100 per unit)* . . . . . # of Units _____
☐ Enhanced Physician Office/Urgent Care Benefit Rider *($25 per unit)* . . . . # of Units _____
☐ Occupational HIV Benefit Rider *($10,000 per unit)* . . . . . # of Units _____
☐ Other _____

Base Plan Weekly Premium $ _____
$ _____
$ _____
$ _____
$ _____
$ _____
$ _____
Total Weekly Premium $ _____

17. Beneficiary

Primary: _____ Relationship _____

18. Employer | Date of Employment | Employee No.

19. Proposed Dependents applying for the Children's Rider

Name *(first)* *(last)*	Date of Birth Mo.	Day	Yr.	Age	Gender M or F	Relationship to Applicant

20. Other Information:

1. Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending? . . . . . ☐ YES ☐ NO
2. Will this insurance replace any other coverage? *(If yes, complete state replacement form if required)* . . . . . ☐ YES ☐ NO
   If "YES" to #1 OR #2, provide name of insurance company and type of insurance: _____

21. Special Requests

AGREEMENT AND DECLARATION - Read Carefully Before Signing

I represent that the statements and answers written in this application parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become a part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application.

C. The insurance applied for shall be in force at 11:59 PM on the date of the application signed by me, provided that the Company approved the application without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

D. The employee will be the owner unless otherwise stated. In the event of the employee's death, ownership will transfer to the primary beneficiary.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices and an Outline of Coverage, *(where applicable).*

F. CAUTION: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Employee *(Owner)* _____

Witnessed *(Licensed Agent)* _____ NPN # _____
(please sign and print your name) *(National Producer Number)*

Dated _____ at _____
(Month, Day, Year) *(City, State)*

PART B: To be completed for any proposed insured who is applying for Sickness-Hospital Confinement Benefit Rider. If the answer is yes to one or more of these questions (A-D) for any proposed insured, the Sickness Hospital Confinement Benefit Rider cannot be offered.

A. In the past 10 years, have any of the proposed insureds had or been told that they had (1) emphysema; (2) high blood pressure for which three or more medications are being taken, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder; (4) insulin-dependent diabetes; (5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder? ☐ *Yes* ☐ *No*

B. In the past 5 years, have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having HIV *(Human Immunodeficiency Virus)* or AIDS *(Acquired Immune Deficiency Syndrome)*? ☐ *Yes* ☐ *No*

C. In the past 2 years, except for normal pregnancy, has any proposed insured been hospitalized or had hospitalization recommended? ☐ *Yes* ☐ *No*

D. Is any proposed insured pregnant or taking fertility drugs? ☐ *Yes* ☐ *No*

Home Office Use Only

NEW ___ ADD___ BOSTON MUTUAL LIFE INSURANCE COMPANY 120 Royall Street
ACCIDENT INSURANCE APPLICATION Canton, MA 02021

PART A:

_____ : Date of Birth __/__/__
_____ : Place of Birth _____
_____ : Age/Gender __ / _____
_____ : Social Sec. # ___-__-____
: Phone # ___-___-____
Employer : _____ : Date of Employment __/__/__
Employee Number : _____
Are you actively at work ? ___

Employee Only _____
Employee/Spouse _____
Employee/Children _____
Employee/Spouse/Children _____

Additional Riders: Base Plan Weekly Premium _____

____ Wellness Benefit Rider _____
____ Sickness-Hospital Confinement Rider (complete part B) _____
____ Emergency Room Benefit Rider # of units_____ _____
($100 per unit)
____ Enhanced Physician Office Benefit Rider # of Units _____ _____
($25 per unit)
____ Occupational HIV Rider _____
($10,000 per unit) # of Units _____
____ Other_____ _____

Total Weekly Premium _____

Beneficiary: Name Relationship Age
Primary- _____ _____ __

Name	Date of Birth	Age	Gender M or F	Relationship to Applicant

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Other Information:

Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending? ____Yes ____No

Will this insurance replace any other coverage? (If yes complete state replacement form if required) ____Yes ____No

If "YES to #1 OR #2, provide name of insurance company and type of insurance:

Special Requests_____

NB1WAP-E 08/08

BOSTON MUTUAL LIFE INSURANCE COMPANY CANTON, MA. 02021

Employee - _____

PART B: To be completed for any proposed insured who is applying for Sickness-Hospital Confinement Rider. If the answer is yes to one or more questions (A-D) for any proposed insured, the Sickness Hospital Confinement Rider cannot be offered.

A. In the past 10 years, have any of the proposed insureds ever had or been told that they had: (1) emphysema; (2) high blood pressure for which three or more medications are being taken, stroke, heart, or circulatory disease or disorder; (3) intestinal disease or disorder; (4) Insulin dependent diabetes;(5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder? ___

B. In the past 5 years, have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)? ___

C. In the past two years, except for normal pregnancy has any of the proposed insureds within the past two (2) years been hospitalized or had hospitalization recommended? ___

D. Is any proposed insured pregnant or taking fertility drugs? ___

Case _____ Payroll _____ Employer _____

NB1WAP-E 08/08

AGREEMENT AND DECLARATION - *** Read Carefully Before Signing ***
I represent that the statements and answers written in this application parts A and B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application.

C. The insurance applied for shall be in force on 11:59 PM on the date of the application signed by me, provided that the Company approved the application without any modification as to plan, amount or premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

D. The employee will be the owner unless otherwise stated. In the event of the employee's death, ownership will transfer to the primary beneficiary.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices and and Outline of Coverage (where applicable).

F. **CAUTION**: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____
Signature of Employee (Owner)

Witnessed (Licensed Agent) _____ NPN# _____
(please sign and print your name) (National Producer Number)

Dated _____ at _____
(Month, Day, Year) (City, State)

Case _____ Payroll _____ Employer _____

NB1WAP-E 08/08

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 11/24/2008

Comments:
Attached is the Arkansas Compliance Certification.

Attachment:
AccWSArkansasCompCert.pdf

Satisfied -Name: Application

Review Status: Approved-Closed 11/24/2008

Comments:
Attached is the application included in this filing. It is the same application, but a paper version and an electronic version. The application for approval is attached to the form schedule also.

Attachments:
AccWSappPaper.pdf
AccWSappElec.pdf

Satisfied -Name: Outline of Coverage

Review Status: Approved-Closed 11/24/2008

Comments:
Attached is the Outline of Coverage.

Attachment:
AccWSoutlineCovArkansas.pdf

Satisfied -Name: Flesch Score Certification

Review Status: Approved-Closed 11/24/2008

Comments:
Attached is the Flesch Score Certification.

Attachment:
AccWSfleschScore.pdf.pdf

Satisfied -Name: Prior approval for replaced forms

Review Status: Approved-Closed 11/24/2008

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Comments:

Attachment:

Prior Policy Approval Information.pdf

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Satisfied -Name: Variability statement

Review Status: Approved-Closed 11/24/2008

Comments:

Attachment:

STATEMENT OF VARIABILITY.pdf

Satisfied -Name: Electronic process explanation

Review Status: Approved-Closed 11/24/2008

Comments:

Attachment:

e-signature process description.pdf

Satisfied -Name: sample policy with changes highlighted

Review Status: Approved-Closed 11/24/2008

Comments:

This policy is substantially similar to previously approved WIND-ACC 11/05. Many of the benefits have been increased or enhanced and the basic coverage can now be taken as either full 24 hours coverage or as non-occupational coverage only.

Attachment:

sample Acc policy with revisions highlighted.pdf

Satisfied -Name: Summary of enhancements

Review Status: Approved-Closed 11/24/2008

Comments:

This policy is substantially similar to previously approved WIND-ACC 11/05. Many of the benefits have been increased or enhanced and the basic coverage can now be taken as either full 24 hours coverage or as non-occupational coverage only. In addition, two additional riders have been added to the package: Enhanced Physician's Office/Urgent Care Rider and Occupational HIV Rider.

A summary of the changes is attached.

Attachment:

Summary of Accident Product Enhancements.pdf

SERFF Tracking Number:	*BSTN-125902180*	*State:*	*Arkansas*
Filing Company:	*Boston Mutual Life Insurance Company*	*State Tracking Number:*	*40896*
Company Tracking Number:	*IND-08-005*		
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*Accident Policy*		
Project Name/Number:	*Worksite Accident Only Policy Revision/IND-08-005*		

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 11/24/2008

Comments:

Attached is the Cover Letter.

Attachment:

AccWScoverLetter.pdf

120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

ARKANSAS COMPLIANCE CERTIFICATION

Accident Product Filing

FORM NUMBER(S):

Accident Policy:	WS-ACC 8/08
Outline of Coverage	WSACCP-OC 08/08
Spouse Accident Rider	SpAcc Rider 8/08
Dependent Children Accident Rider	CA-Rider 8/08
Enhanced Physician Office/Urgent Care Rider	EPO-Rider 8/08
Enhanced Emergency Room Benefit Rider	EER-Rider 8/08
Wellness Benefit Rider	WB-Rider 8/08
Occupational HIV Benefit Rider	OHIV-Rider 8/08
Sickness-Hospital Confinement Benefit Rider	SH-Rider 8/08
Application (hard copy/lap top version)	WSA-P 8/08
Application (print-out of lap top screen)	WSA-E 8/08

Having carefully reviewed the above numbered form(s), we hereby certify, to the best of our knowledge, information and ability that, as applicable, the forms in this filing:

1. Conforms in all aspects to the provisions of Arkansas Rule and Regulation 19, Rule and Regulation 49, Flesch Scoring Requirements and Consumer Notice of Information, as well as all applicable requirements of the Insurance Department of Arkansas;

2. Said form(s) contain no provision or provisions previously disapproved or called to our attention by the Insurance Department of Arkansas.

Signed: Richard J. Miller

Richard J. Miller
Director, Contracts & Compliance

Date: November 20, 2008

NEW ☐ ADD ☐

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street
Canton, MA 02021

ACCIDENT INSURANCE APPLICATION

PART A:

1. Proposed Insured *(Employee)*				2. ☐ M Gender ☐ F	7. Proposed Insured *(Spouse)*			8. ☐ M Gender ☐ F
3. Date of Birth	4. Age	5. Place of Birth State	6. Phone No. ( )		9. Date of Birth			10. Age

11. Present Residence

No. Street City State Zip

12. Mailing Address *(if different)*

13. S.S. No. *(Employee)*

14. Are you actively at work? ☐ YES ☐ NO

15. Plan *(select one)*

☐ Employee Only-*Weekly Premium* [ ]
☐ Employee/Spouse-*Weekly Premium* [ ]
☐ Employee/Children-*Weekly Premium* [ ]
☐ Employee/Spouse/Children-*Weekly Premium* [ ]

16. Additional Riders:

☐ Wellness Benefit Rider . . . . .
☐ Sickness-Hospital Confinement Benefit Rider *(complete Part B)* . . . . .
☐ Enhanced Emergency Room Benefit Rider *($100 per unit)* . . . . . # of Units _____
☐ Enhanced Physician Office/Urgent Care Benefit Rider *($25 per unit)* . . . . # of Units _____
☐ Occupational HIV Benefit Rider *($10,000 per unit)* . . . . . # of Units _____
☐ Other _____

Base Plan Weekly Premium $ _____
$ _____
$ _____
$ _____
$ _____
$ _____
$ _____
Total Weekly Premium $ _____

17. Beneficiary

Primary: _____ Relationship _____

18. Employer	Date of Employment	Employee No.

19. Proposed Dependents applying for the Children's Rider

Name *(first)* *(last)*	Date of Birth Mo.	Day	Yr.	Age	Gender M or F	Relationship to Applicant

20. Other Information:

1. Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending? . . . . . ☐ YES ☐ NO
2. Will this insurance replace any other coverage? *(If yes, complete state replacement form if required)* . . . . . ☐ YES ☐ NO
   If "YES" to #1 OR #2, provide name of insurance company and type of insurance: _____

21. Special Requests

AGREEMENT AND DECLARATION - Read Carefully Before Signing

I represent that the statements and answers written in this application parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become a part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application.

C. The insurance applied for shall be in force at 11:59 PM on the date of the application signed by me, provided that the Company approved the application without any modification as to plan, amount of premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

D. The employee will be the owner unless otherwise stated. In the event of the employee's death, ownership will transfer to the primary beneficiary.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices and an Outline of Coverage, *(where applicable)*.

F. CAUTION: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Employee *(Owner)* _____

Witnessed *(Licensed Agent)* _____ NPN # _____
(please sign and print your name) *(National Producer Number)*

Dated _____ at _____
(Month, Day, Year) *(City, State)*

(PART B CONTINUES ON REVERSE)

PART B: To be completed for any proposed insured who is applying for Sickness-Hospital Confinement Benefit Rider. If the answer is yes to one or more of these questions (A-D) for any proposed insured, the Sickness Hospital Confinement Benefit Rider cannot be offered.

A. In the past 10 years, have any of the proposed insureds had or been told that they had (1) emphysema; (2) high blood pressure for which three or more medications are being taken, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder; (4) insulin-dependent diabetes; (5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder? ☐ *Yes* ☐ *No*

B. In the past 5 years, have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having HIV *(Human Immunodeficiency Virus)* or AIDS *(Acquired Immune Deficiency Syndrome)*? ☐ *Yes* ☐ *No*

C. In the past 2 years, except for normal pregnancy, has any proposed insured been hospitalized or had hospitalization recommended? ☐ *Yes* ☐ *No*

D. Is any proposed insured pregnant or taking fertility drugs? ☐ *Yes* ☐ *No*

Home Office Use Only

NEW ___ ADD___ BOSTON MUTUAL LIFE INSURANCE COMPANY 120 Royall Street
ACCIDENT INSURANCE APPLICATION Canton, MA 02021

PART A:

_____ : Date of Birth __/__/__
_____ : Place of Birth _____
_____ : Age/Gender __ / _____
_____ : Social Sec. # ___-__-____
: Phone # ___-___-____
Employer : _____ : Date of Employment __/__/__
Employee Number : _____
Are you actively at work ? ___

Employee Only _____
Employee/Spouse _____
Employee/Children _____
Employee/Spouse/Children _____

Additional Riders: Base Plan Weekly Premium _____

____ Wellness Benefit Rider _____
____ Sickness-Hospital Confinement Rider (complete part B) _____
____ Emergency Room Benefit Rider # of units_____ _____
($100 per unit)
____ Enhanced Physician Office Benefit Rider # of Units _____ _____
($25 per unit)
____ Occupational HIV Rider _____
($10,000 per unit) # of Units _____
____ Other_____ _____

Total Weekly Premium _____

Beneficiary: Name Relationship Age
Primary- _____ _____ __

Name	Date of Birth	Age	Gender M or F	Relationship to Applicant

---

Other Information:

Do you or any person to be insured have any accident insurance, excluding an employer's group plan, or any application for such insurance pending? ____Yes ____No

Will this insurance replace any other coverage? (If yes complete state replacement form if required) ____Yes ____No

If "YES to #1 OR #2, provide name of insurance company and type of insurance:

Special Requests_____

NB1WAP-E 08/08

BOSTON MUTUAL LIFE INSURANCE COMPANY CANTON, MA. 02021

Employee - _____

PART B: To be completed for any proposed insured who is applying for Sickness-Hospital Confinement Rider. If the answer is yes to one or more questions (A-D) for any proposed insured, the Sickness Hospital Confinement Rider cannot be offered.

A. In the past 10 years, have any of the proposed insureds ever had or been told that they had: (1) emphysema; (2) high blood pressure for which three or more medications are being taken, stroke, heart, or circulatory disease or disorder; (3) intestinal disease or disorder; (4) Insulin dependent diabetes;(5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder? ___

B. In the past 5 years, have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)? ___

C. In the past two years, except for normal pregnancy has any of the proposed insureds within the past two (2) years been hospitalized or had hospitalization recommended? ___

D. Is any proposed insured pregnant or taking fertility drugs? ___

Case _____ Payroll _____ Employer _____

NB1WAP-E 08/08

AGREEMENT AND DECLARATION - *** Read Carefully Before Signing ***
I represent that the statements and answers written in this application parts A and B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agreed that:

A. This application and any supplement shall form the basis for and become part of any policy issued.

B. The agent has no authority to waive the answer to any question in, or to modify, the application.

C. The insurance applied for shall be in force on 11:59 PM on the date of the application signed by me, provided that the Company approved the application without any modification as to plan, amount or premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

D. The employee will be the owner unless otherwise stated. In the event of the employee's death, ownership will transfer to the primary beneficiary.

E. I have received a copy of Boston Mutual's Notice of Information Privacy Practices and and Outline of Coverage (where applicable).

F. **CAUTION:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____
Signature of Employee (Owner)

Witnessed (Licensed Agent) _____ NPN# _____
(please sign and print your name) (National Producer Number)

Dated _____ at _____
(Month, Day, Year) (City, State)

Case _____ Payroll _____ Employer _____

NB1WAP-E 08/08

Boston Mutual Life Insurance Company
120 Royall Street, Canton, Massachusetts 02021
800-669-2668

CCIDENT-ONLY COVERAGE
THE POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE POLICY FORM WS-ACC 8/08

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.
READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Boston Mutual Life Insurance Company. It is therefore important that you **READ YOUR POLICY CAREFULLY.**

Accident-only coverage is designed to provide you with coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS. The benefits under the policy are available for any insured person who is injured or who dies as a result of a ***covered accident***. A ***covered accident*** is an injury which occurs after the Policy Effective Date and occurs while the Policy is force if it is not excluded by name or specific description. If Off-the-Job Coverage is selected, a ***covered accident*** does not include any injury which occurs while the Insured Person is working for pay or profit.

The following is a brief description of the benefits provided by the policy for a ***covered accident***. Review the policy for any limitations, and exclusions for each of the benefits.
Accidental Death Benefit pays an accidental death benefit for death as a result of a covered accident.
Accidental Death – Common Carrier Benefit pays an accidental death benefit as a result of a covered accident while a fare paying passenger(excludes taxis and privately chartered vehicles).
Accident Follow-Up Treatment Benefit pays $50 for follow-up treatment.
Air Ambulance Benefit pays $500 for a licensed professional air ambulance company.
Ambulance Benefit pays $100 for a licensed professional ambulance company.
Appliance Benefit pays $100 for the use of a medical appliance as an aid in personal locomotion or mobility.
Blood/Plasma/ Platelets Benefit pays $300 for the transfusion, administration, cross-matching, typing and processing of blood, blood plasma and platelets.
Burn Benefit pays the applicable amount listed in the policy.
Catastrophic Accident Benefit pays the applicable benefit amount shown in the Policy Schedule.
Concussion Benefit pays $100 for any type of medical imaging procedure such as an x-ray, CT scan and/or MRI.
Dislocated (Separated Joint) Benefit pays the applicable amount listed in the policy.
Emergency Dental Work Benefit pays the applicable amount listed in the policy.
Emergency Room Treatment Benefit pays $50 for examination and treatment in an emergency room
Eye Injury Benefit pays $200 for surgery or the removal of a foreign object from the eye.
Fracture Benefit (Broken Bone) pays the applicable benefit amount listed in the policy.
Hospital Admission Benefit pays $1,000 when confined to a hospital ($2,000 if immediately admitted to an Intensive Care Unit)
Hospital Confinement Benefit pays $250 per day for up to 365 days when confined in a hospital or a hospital sub-acute intensive care unit.
Hospital Intensive Care Unit Confinement Benefit pays $500 per day for up to 30 days when confined to a hospital intensive care unit.
Knee Cartilage – Torn Benefit pays $750 for a torn knee cartilage.

Laceration Benefit pays the applicable amount listed in the policy.
Lodging Benefit pays $100 per night for up to 30 days for one motel/hotel room for a companion to accompany insured person.
Loss of Finger, Toe, Hand, Foot or Sight of an Eye Benefit pays the applicable amount listed in the policy.
Major Diagnostic Exams Benefit pays $150 per calendar year for CT Scan, MRI or EEG.
Physical Therapy Benefit pays $25 per day for physical therapy for a maximum of six days.
Physician's Office/Urgent Care Benefit pays $50 for initial treatment by a physician.
Prosthetic Device/Artificial Limb Benefit pays the applicable amount listed in the policy.
Rehabilitation Unit Benefit pays $150 per day for up to 30 days when confined in a Rehabilitation Unit.
Ruptured Disc Benefit pays $400 for a ruptured disc**.**
Skin Grafts Benefit pays 25% of the applicable Burn benefit amount.
Surgery Benefit pays $1,000 for open abdominal or thoracic surgery within 72 hours of covered accident.
Tendon/Ligament/Rotator Cuff Benefit pays the applicable amount listed in the policy.
Transportation Benefit pays $300 per round trip if traveling more than 100 miles for special treatment or confinement.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for losses that are caused by or are the result of any insured person(s):

1) practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
2) having any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any injury;
3) intentionally self-inflicted injury;
4) committing suicide or attempted suicide, while sane or insane;
5) receiving injuries due to an act of declared or undeclared war;
6) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or any Military Reserve;
7) driving any taxi for wage, compensation, or profit;
8) having Mental or Emotional Disorders;
9) suffering from alcoholism or drug addiction;
10) suffering from a loss sustained or contracted as the result of being physically or mentally impaired due to being under the influence of alcohol or any illicit or Controlled Substance unless administered on the advice of a Physician; "Being under the influence of alcohol", for purposes of this policy, means a blood alcohol level of 0.08 or more. The Insured Person's alcohol or illicit or controlled substance impairment must be the cause or contributing cause of his or her loss, irrespective of whether the loss occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
11) sustaining a loss to which a contributing cause was the commission of or an attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was being engaged in an illegal activity.

If Non-Occupational Coverage is issued, the following exclusion will also apply.
(12) incurring an injury while the Insured Person is working for pay or profit.

RENEWABILITY. The policy is guaranteed renewable for life. We will renew the policy each time you send us a premium. It must be paid on or before the date it is due or during the 31 days that follow.
PREMIUM CHANGE. We may change the premium rates for this policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class and in the same state where your policy was issued.

		Premium
BASE PLAN		
☐	**ACCIDENT INSURANCE POLICY FORM WS-ACC 8/08 24 HOUR COVERAGE**	**$_____**
☐	**ACCIDENT INSURANCE POLICY FORM WS-ACC 8/08 NON-OCCUPATIONAL COVERAGE**	**$_____**
OPTIONAL RIDERS		
☐	**Spouse Accident Insurance Rider - Form SpAcc-Rider 8/08** If the rider is selected coverage will be issued for your spouse	**$_____**
☐	**Dependent Children Accident Insurance Rider - Form CA-Rider 8/08** If the rider is selected coverage will be issued for your dependent children	**$_____**
☐	**Enhanced Emergency Room Benefit Rider - Form EER-Rider 8/08** This rider provides a benefit when treated in an emergency room and is paid in addition to the Emergency Room Treatment Benefit in the policy.	**$_____**
☐	**Wellness Benefit Rider - Form WB-Rider 8/08** The rider provides benefits for certain health screening tests performed by a physician	**$_____**
☐	**Sickness-Hospital Confinement Benefit Rider - Form SH-Rider 8/08** The rider provides a daily benefit amount when confined in a hospital due to a sickness.	**$_____**
☐	**Enhanced Physician Office/Urgent Care Treatment Benefit Rider - Form EPO-Rider 8/08** The rider provides a benefit when treated by a physician in a physician's office or Urgent Care facility and is paid in addition to the Physician Office/Urgent Care benefit in the policy.	**$_____**
☐	**Occupational HIV Benefit Rider - Form OHIV-Rider 8/08** The rider provides a lump sum benefit upon the positive diagnosis of Occupational HIV (Human Immunodeficiency Virus). This rider is not available with the Non-Occupational Coverage option.	**$_____**

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

I certify to the best of my knowledge and belief that these forms are in compliance with the NAIC Model Act regarding Simplified and Readable Life Insurance Policies.

I also certify that the Flesch scores for the form(s) contained in this submission are as indicated below.

FORM #	FLESCH SCORE
WS-ACC 8/08 - Accident Policy	50.9
WSACC-OC 8/08 - Outline of Coverage	51.7
SpAcc-Rider 8/08 – Spouse Accident Rider	50.3
CA-Rider 8/08 – Dependent Child Accident Rider	51.6
EER-Rider 8/08 - Enhanced Emergency Room Rider	51.6
WB-Rider 8/08 - Wellness Benefit Rider	52.3
EPO-Rider 8/08 – Enhanced Physician's Office/Urgent Care Rider	57.3
OHIV-Rider 8/08 – Occupational HIV Benefit Rider	52.3
SH-Rider 8/08 - Sickness Hospital Benefit Rider	51.5
NB1-WAP-P 8/08 – Hard copy/Lap Top application	55.6
NB1-WAP-E 8/08 – Print out of Lap top application	55.6

Richard J. Miller
Director, Contracts & Compliance
Boston Mutual Life Insurance Co.

Date: October 15, 2008

Prior Policy Approval Information
WS-ACC 8/08 - replaces WIND-ACC 11/05

STATE	APPROVAL INFORMATION	FORM NUMBER	NOTES
Alaska	Approved 3/13/06 State # 65175 SERFF # SERT-6LYKLV136	WIND-ACC 11/05 AK	
Alabama	Approved 1/23/06 SERFF # SERT-6KTGBA261	WIND-ACC 11/05 AL	
Arizona	Closed – Exempt SERFF # SERT-6KTGD5783	WIND-ACC 11/05 AZ	
Arkansas	Approved 3/25/06 State # 31944	WIND-ACC 11/05 AR	SERFF # SERT-6LYKN768
California	Approved 10/16/06 State # 06-51262	WIND-ACC 11/05 CA	
Colorado	Forms approved 3/20/06 SERFF # SERT-6LYT9L592 Rates approved 5/22/06	WIND-ACC 11/05 CO	SERFF # SERT 6YLTGD800
Connecticut	Approved 9/28/06 State # 44154	WIND-ACC 11/05 CT	SERFF # SERT-6SRQE4670
Delaware	Approved 3/13/06 State # 3039	WIND-ACC 11/05 DE	SERFF # SERT-6LYTKC416
D. of Columbia	Approved 7/7/06	WIND-ACC 11/05 (standard forms)	
Florida	Approved 7/6/06 State # FLH-06-06963	WIND-ACC 11/05 FL	
Georgia	Approved 6/7/06	WIND-ACC 11/05 GA	
Hawaii	Approved 1/30/07 State # 114712	WIND-ACC 11/05 HI	
Idaho	Approved 6/20/06 State # 176405	WIND-ACC 11/05 ID	SERFF # SERT-6QKPNS778
Illinois	Forms approved 7/26/06 State # BMACCIDENTFORM Outline approved 7/26/06 State # BMACCIDENTOUT Rate approved 7/26/06 State # BMACCIDENTRATERAT	WIND-ACC 11/05 IL	Ser# SERT-KSJWQ734 Sert # SERT-KSJXY383 Ser # SERT-KSJYW903
Indiana	Approved 9/1/06	WIND-ACC 11/05 IN	Rates OK-CIC Powell
Iowa	Approved 1/24/07 State # WAKE-125072200	WIND-ACC 11/05 IA	SERFF # is same as state
Kansas	Approved 6/16/06 SERFF# SERT-6Q5J5R733	WIND-ACC 11/05 KS	
Kentucky	Approved 4/10/06 State # 2006-004964	WIND-ACC 11/05 KY	SERFF # SERT-6KVTBX632
Louisiana	Approved 2/16/06 State # 2060702	WIND-ACC 11/05 LA	
Maine	Approved 7/25/06 SERFF # SERT-6QHS8H159	WIND-ACC 11/05 ME	
Maryland	Approved 9/8/06 State # WIND-ACC11/05MD	WIND-ACC 11/05 MD	SERFF # SERT-6LST9L383
Massachusetts	Forms approved 5/19/06 SRB # 98697 and 98691 Rates approved 10/16/06	WIND-ACC 11/05 MA	
Michigan	Filed Exempt 3/20/06	WIND-ACC 11/05 MI	
Minnesota	Approved 10/13/06 State # 2600309	WIND-ACC 11/05 MN	SERFF # SERT-6L4KBK146
Mississippi	Approved 8/29/06 State # SERT-6L6QZH107	WIND-ACC 11/05 MS	
Missouri	Approved 1/25/06	WIND-ACC 11/05 MO	SERFF # SERT-

	State # 0601240003		6L4K7X988
Montana	Approved 8/15/06	WIND-ACC 11/05 MT	SERFF # SERT – 6QD52Z866
Nebraska	Approved 4/3/06	WIND-ACC 11/05 (standard forms)	SERFF # SERT-6M2JHL133
Nevada	Filed 5/2/06	WIND-ACC 11/05 NV	Paper filing – no state #
New Hampshire	Approved 8/29/06	WIND-ACC 11/05 NH	SERFF # SERT-6QD4U9867
New Jersey	Approved 8/30/06 State # 0609628	WIND-ACC 11/05 NJ	SERFF # SERT-6LFMTM274
New Mexico	Approved 3/10/06 SERT-6M3HQM827	WIND-ACC 11/05 NM	
N. Carolina	Approved 2/19/07 State # LH064864	WIND-ACC 11/05 NC	
N. Dakota	Approved 5/24/06 State # 54027	WIND-ACC 11/05 ND	SERFF # SERT-6MWQG9200
Ohio	Approved 2/17/06	WIND-ACC 11/05 OH	SERFF # SERT-6L4KGY688
Oklahoma	Approved 7/11/06 SERT-6M3J35798	WIND-ACC 11/05 OK	
Oregon	Approved 5/11/07 State # MH 0002 07	WIND-ACC 11/05 OR	SERFF # WAKE-125072201
Pennsylvania	Approved 1/19/07 State # A94153001	WIND-ACC 11/05 PA	SERFF # SERT-6KSPVE784
Rhode Island	Approved 5/25/06 SERT-6M3J4N741	WIND-ACC 11/05 RI	
S. Carolina	Approved 3/10/06 State # 185775	WIND-ACC 11/05 SC	SERFF # SERT-6L4K9Q684
S. Dakota	Approved 7/11/06 State # 195707	WIND-ACC 11/05 SD	SERFF # SERT-6QAKB7309
Tennessee	Approved 9/13/08 State # H-060230	WIND-ACC 11/05 TN	Paper filing only
Texas	Approved 1/30/06 Filing ID 2651893-0 thru -9	WIND-ACC 11/05 TX	Filed Exempt Paper filing only
Utah	Approved 6/11/08 State # 67099	WIND-ACC 11/05 UT	SERFF # WAKE-125312738
Vermont	Approved 6/13/07 State # 27111	WIND-ACC 11/05 VT	SERFF # SERT-6S2LSB439
Virginia	Approved 9/11/07 State # 7/27959	WIND-ACC 11/05 VA	SERFF # WAKE-125072203
Washington	Forms approved 10/3/06 Rates approved 10/4/06	WIND-ACC 11/05 WA	Two separate filings for forms and rates SERT-4SA4NH101 & SERT6SA4PU240
W. Virginia	Approved 4/3/06 State # 60307002	WIND-ACC 11/05 WV	SERFF# SERT-6M8KSC777
Wisconsin	Approved 6/21/06	WIND-ACC 11/05 WI	SERFF # SERT-6LSTGS523
Wyoming	Approved 3/23/06 SERT-6MWQT2517	WIND-ACC 11/05 WY	

BOSTON MUTUAL LIFE INSURANCE COMPANY

STATEMENT OF VARIABILITY

RE: Individual Accident Only policy package: WS-ACC 8/08 et al

This policy contains bracketed variable text on the following pages:

Page One: [Non-Occupational] The policy can be issued as a traditional 24 hour accident product or as a non-occupational only accident product, based on the choice made by the employer where the worksite product enrollment is conducted. This option is offered to help prevent over-insurance that might lead to abuse of workers-compensation benefits.

Page Four: [[A Covered Accident does not include any Injury which occurs while the Insured Person is working for pay or profit]. As indicated, this text would be added only if the policy were issued as non-occupational.

Page Six: [(12) incurring an injury while the Insured Person is working for pay or profit.] As indicated, this exclusion would be added only if the policy were issued as non-occupational but would not be included if the policy were a traditional 24 hour coverage.

No other variable text is found in the benefit provisions of this policy except as indicated below:

Policy specific data such as the name of the insured, premium etc found at the bottom of page 1 and on pages PS and TV.

The address and contact information of the company has also been bracketed to allow for future change.

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

ELECTRONIC APPLICATION AND SIGNATURE PROCESS

The Boston Mutual Worksite electronic application process begins with the applicant sitting with an enroller:

1. The applicant and the enroller view the application on a lap-top computer screen and complete the application questions using the key board;
2. Upon completion of the screen application, the applicant presses a key to accept the application;
3. The attached screen appears, completed with the date and the insured's name;
4. After reading the screen, the applicant chooses to "Accept" or "Reject" the completed application;
5. If the applicant "Accepts" the completed form, than an encrypted control code is assigned to the form and the form can be submitted to the home office for processing;
6. The accepted application is encrypted with the date and time and changes cannot be made to the submitted text;
7. Upon acceptance of the risk by the home office, the e-application is printed and a hard copy is attached to the issued policy and added to a paper application record that is kept on file in the home office. The printed application shows, "E-signed" and the date and time. A sample copy of an application signed through this process is attached.

Note: Disclosure, Notice of Information Privacy Practices, and replacement forms are presented to the applicant and/or completed in hard copy and if required, transmitted to the home office by mail. Signatures on these forms are hand written rather than electronic.

THIS POLICY IS SUBSTANTIALLY THE SAME AS PREVIOUSLY APPROVED POLICY WIND-ACC 11/05
THIS SAMPLE POLICY SHOWS THE CHANGES AND/OR HIGHLIGHTED UPDATES

ACCIDENT POLICY
GUARANTEED RENEWABLE FOR LIFE
[NON-OCCUPATIONAL]

the policy can now be issued as either full 24 hour accident coverage or as non-occupational accident coverage only

THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY.

The premium You paid and the application You completed put this Policy in force as of the Policy Effective Date. The Policy Effective Date is shown on the Policy Specification Page (Page 3). A copy of Your application is attached.

PART A IMPORTANT PLEASE READ

all heading and sections have been reformatted to remove boxes.

Your application is a part of the Policy. PLEASE READ the copy of Your application. If anything in it is not correct You should tell Us. Your Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid. No associate (duly licensed agent) may change this Policy or waive any of its provisions.

PART B 30 DAY RIGHT TO EXAMINE POLICY

It is important to Us that You are satisfied with this Policy. If You are not satisfied, send it back to Us within 30 days after You have received it. We will send back Your money and the Policy will be considered to have never been in force.

PART C RENEWAL AGREEMENT

We will renew Your Policy each time You send Us the premium. It must be paid on or before the date it is due or during the 31 days that follow. Your Policy stays in force during this time unless You have requested termination of this Policy. Benefits and Policy provisions will be administered based upon the laws of the state where this Policy is issued.

PART D PREMIUM CHANGE

We may change the premium rates for this Policy. We can only change the premium if We change it for all Policies like Yours in Your class and in the same state where Your Policy was issued. “Class” means any group of persons insured individually under this Policy who have a common bond, such as, but not limited to: age, sex, occupation, premium payment method or geographical area.

Any change in premium will be explained to You in writing 31 days or more before the change is effective. We will write You at the address on Our records. Please notify Us of any change in address so Our records are updated.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

-TABLE OF CONTENTS-

WHERE TO FIND IT

POLICY SPECIFICATION PAGE

BENEFICIARY - AS DESIGNATED IN THE APPLICATION SUBJECT TO THE PROVISIONS OF THE POLICY.

***** THE PREMIUMS ARE DUE [TWELVE] TIMES A YEAR STARTING FROM THE DATE OF ISSUE****

SCHEDULE OF BENEFITS BENEFIT	AMOUNT	SCHEDULE OF PREMIUMS PAYABLE FOR	
BASIC POLICY BENEFITS		[$180.57	LIFE]
AMOUNT OF COVERAGE:	$ 50,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$100,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$100,000		
AMOUNT OF COVERAGE ON OR AFTER AGE 70	$ 50,000		
[SPOUSE ACCIDENT BENEFIT		$ 90.28	LIFE]
INSURED SPOUSE: JOHN DOE			
AMOUNT OF COVERAGE:	$ 50,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$100,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$100,000		
AMOUNT OF COVERAGE ON OR AFTER AGE 70	$ 50,000		
[DEPENDENT CHILDREN BENEFIT		$148.57	LIFE]
AMOUNT OF COVERAGE:	$ 10,000		
COMMON CARRIER ACCIDENT AMOUNT OF COVERAGE	$ 20,000		
CATASTROPHIC ACCIDENT AMOUNT OF COVERAGE	$ 50,000		
[ENHANCED EMERGENCY ROOM BENEFIT RIDER		$157.68	LIFE]
AMOUNT OF COVERAGE: [$300]			
[WELLNESS BENEFIT RIDER		$ 45.70	LIFE]
AMOUNT OF COVERAGE $50 PER CAL YR			
[SICKNESS-HOSPITAL CONFINEMENT BENEFIT RIDER		$ 91.41	LIFE]
AMOUNT OF COVERAGE $100 PER DAY			
[ENHANCED PHYSICIAN OFFICE / URGENT CARE TREATMENT BENEFIT RIDER		$ 51.42	LIFE]
AMOUNT OF COVERAGE: [$50]			
[OCCUPATIONAL HIV BENEFIT RIDER		$114.20	LIFE]
AMOUNT OF COVERAGE: [$50,000]			
TOTAL ANNUAL PREMIUM (AT ISSUE)		[$879.83]	

PREMIUMS IF PAID:

	ONCE A YEAR	TWICE A YEAR	FOUR TIMES A YEAR	MONTHLY SPECIAL BILL
	[$879.83	$453.12	$228.76	$ 76.99]
PER YEAR	[$879.83	$906.24	$915.04	$923.88]

****

ACCIDENT POLICY
GUARANTEED RENEWABLE FOR LIFE

****

PRIMARY INSURED [JANE DOE] [123456] POLICY NUMBER
OWNER [JANE DOE] DATE OF ISSUE [JAN 1, 2008]
[FAMILY] TYPE OF COVERAGE ISSUE AGE[35 FEMALE]

PART E DEFINITIONS

When We use the following words, this is what We mean:

"Calendar Year" means the period of time that begins on January 1 and ends on December 31, of the same year.

"Catastrophic Loss" means an Injury that within 365 days of the Covered Accident results in total and irrecoverable: (a) loss of both hands or both feet; or (b) loss or loss of use of both arms or both legs; or (c) loss of one hand or one foot; or (d) loss or loss of use of one arm or one leg; or (e) loss of the sight of both eyes; or (f) loss of the hearing in both ears; or (g) loss of the ability to speak.

The "loss of use of an arm" means the loss of function of the entire arm from the shoulder to the hand. The "loss of use of a leg" means the loss of function of the entire leg from the hip to the foot. The "loss of sight" means both eyes are totally blind and that no sight can be restored. The "loss of hearing" means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. The "loss of the ability to speak" means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

"Common Carrier" means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered vehicles are not Common Carriers.

"Confined" or "Confinement" means the assignment to a bed as a resident inpatient in a Hospital on the advice of a Physician or Confinement in an Observation Unit within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

"Controlled Substance" is a drug classified as such by the Drug Enforcement Administration of the Department of Justice.

"Covered Accident" is an Injury which: (a) occurs after the Policy Effective Date; (b) occurs while this Policy is in force; and (c) is not excluded by name or specific description in this Policy. [A Covered Accident does not include any Injury which occurs while the Insured Person is working for pay or profit]. This text will appear when the coverage in non-occupational only

"Emergency Room" is a specified area within a Hospital that is designated for the emergency care of accidental injuries. This area must: (a) be staffed and equipped to handle trauma; (b) be supervised and provide treatment by Physicians; and (c) provide care seven days per week, 24 hours per day. An Urgent Care Facility is not considered an Emergency Room.

"Hospital" means a primary care Hospital operated pursuant to law. The Hospital has organized facilities to provide first level treatment of sick and injured persons on an inpatient basis for which a charge is made. Organized facilities include emergency services, admissions services, clinical laboratory, diagnostic X-ray and an operating room.

Treatment facilities for emergency, medical and surgical services must be provided within the Hospital. The Hospital must provide 24 hour nursing services by or under the supervision of an R.N. (graduate registered Nurse), and be supervised by a staff of one or more Physicians. The Hospital also maintains on its premises the patient's written history and medical records.

Not included is a Hospital or institution or part of such Hospital or institution which is licensed or used principally as: (a) a hospice unit (including any beds designated as a hospice bed); (b) a swing bed; (c) a convalescent home; (d) a rest or nursing facility; (e) a skilled nursing facility; (f) a psychiatric unit; (g) a rehabilitation unit or facility; or (h) a facility primarily affording custodial care, educational care or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, drug addicts or alcoholics.

"Hospital Intensive Care Unit" means a place which: (a) is a specifically designated area of the Hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement; (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; (d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and (e) has a Physician assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care Unit is not any of the following step down units: (a) a progressive care unit; (b) an intermediate care unit; (c) a private monitored room; (d) sub-acute intensive care unit; (e) an Observation Unit; or (f) any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this Policy.

"Hospital Sub-Acute Intensive Care Unit" means a place which: (a) is a specifically designated area of the *hospital* that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward; (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement; (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and (d) is under constant and continuous observation by a specially trained nursing staff.
A Hospital Sub-Acute Intensive Care Unit may be referred to by other names such as progressive care, intermediate care, or a step-down unit, but it is not a regular private or semi-private room, or ward with or without monitoring equipment.

"Immediate Family" means the spouse, father, mother, sons, daughters, brothers or sisters of any Insured Person.

"Injury" means bodily harm caused by external and unexpected means and not contributed to by any other cause.

All injuries sustained in any one accident and all complications and re-occurrences of complications are considered to be a single Injury.

"Insured Person" means You and, if covered under an optional attached Rider, Your spouse and/or a dependent child.

"Mental or Nervous Disorder" means all conditions classified as mental disorders by the International Classification of Diseases including, but not limited to, psychoses, neurotic disorders, personality disorders, non-psychotic mental disorders or mental retardation whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement.

"Observation Unit" is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient surgery or treatment in the Emergency Room by a Physician and which: (a) is under the direct supervision of a Physician or registered nurse; (b) is staffed by nurses assigned specifically to that unit; and (c) provides care seven days per week, 24 hours per day.

"Physical Therapist" is a person, other than You or an Immediate Family member, who: (a) is licensed by the state to practice physical therapy; (b) performs services which are allowed by his license; (c) performs services for which benefits are provided by this Policy; and (d) practices according to the Code of Ethics of the American Physical Therapy Association.

"Physician" means a doctor of medicine or an osteopath who is duly licensed by the state medical board. Such person must not be the Primary Insured or any Insured Person's Immediate Family member and must be providing services within the scope of his or her license. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible physicians.

PART E DEFINITIONS CONTINUED

"Policy Effective Date" means the date on which this coverage shall begin. Coverage begins at 11:59 P.M. on the date the application is signed by You, provided the Company has approved the coverage applied for and has received the necessary policy premiums.

"Primary Insured" means the person named as the Primary Insured on the Policy Specification Page (Page 3).

"Rehabilitation Unit" means a designated area of a hospital or a free-standing facility which is not part of a hospital, which provides physical, occupational or speech therapy on a short term basis.

"Urgent Care Facility" means a free-standing facility, which is not part of a Hospital, or Hospital Emergency Room, which provides care on an urgent basis.

"We", "Our" or "Us" means Boston Mutual Life Insurance Company.

"You" *or* "Your" means the person named as the Primary Insured on the Policy Specification Page (Page 3). You are insured for the benefits of the Policy as of the Policy Effective Date.

PART F EXCLUSIONS

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for losses that are caused by or are the result of any Insured Person:

(1) practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
(2) having any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by any Injury;
(3) intentionally self-inflicted Injury;
(4) committing suicide or attempted suicide, while sane or insane;
(5) receiving injuries due to an act of declared or undeclared war;
(6) actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or any Military Reserve;
(7) driving any taxi for wage, compensation, or profit;
(8) having Mental or Nervous Disorders;
(9) suffering from alcoholism or drug addiction;
(10) suffering from a loss sustained or contracted as the result of being physically or mentally impaired due to being under the influence of alcohol or any illicit or Controlled Substance unless administered on the advice of a Physician; "Being under the influence of alcohol", for purposes of this Policy, means a blood alcohol level of 0.08 or more. The Insured Person's alcohol or illicit or Controlled Substance impairment must be the cause or contributing cause of his or her loss, irrespective of whether the loss occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
(11) sustaining a loss to which a contributing cause was the commission of or an attempt to commit a felony. Nor will We be liable for any loss to which a contributing cause was being engaged in an illegal activity.

[(12) incurring an injury while the Insured Person is working for pay or profit.] This exclusion appears in the non-occupational coverage only

PART G BENEFITS

This policy will pay the following benefits for loss resulting from a Covered Accident:

ACCIDENTAL DEATH: The benefit amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident, and the Injury causes any Insured Person to die within 90 days after the Covered Accident.

ACCIDENTAL DEATH-COMMON CARRIER: The benefit amount shown on the Policy Specification Page (Page 3) if any Insured Person is injured as the result of a Covered Accident while a fare paying passenger on a Common Carrier and the Injury causes any Insured Person to die within 90 days after the Covered Accident. If We pay this benefit, We will not pay the Accidental Death benefit.

ACCIDENT FOLLOW-UP TREATMENT: $50 if any Insured Person receives follow-up treatment that is recommended or advised by a Physician for injuries received as the result of a Covered Accident. Follow-up treatment must:

(1) be within 90 days of the Covered Accident;
(2) occur after initial treatment in a Physician's office or Emergency Room; and
(3) not be for routine examinations or preventive testing.

We will pay this amount once per Covered Accident.

AIR AMBULANCE: $500 if a licensed professional air ambulance company transports by air any Insured Person to or from a Hospital or between medical facilities, where treatment for injuries is received as the result of a Covered Accident. The air ambulance transportation must be within 48 hours after the Covered Accident. We will pay this amount once per Covered Accident.

AMBULANCE: $100 if a licensed professional ambulance company transports any Insured Person by ground transportation to or from a Hospital or between medical facilities, where treatment for injuries is received as the result of a Covered Accident. The ambulance transportation must be within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

APPLIANCE: $100 if any Insured Person is injured as the result of a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches and wheelchairs are examples of medical appliances. The use of an appliance must begin within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

BLOOD/PLASMA/PLATELETS: $300 if any Insured Person is injured as the result of a Covered Accident and requires the transfusion, administration, cross-matching, typing and processing of blood, blood plasma and platelets as the result of the Injury. The blood, blood plasma and platelets must be administered within 90 days after the Covered Accident. We will pay this amount once per Covered Accident.

BURN: The applicable amount listed below if any Insured Person receives burns as the result of a Covered Accident which are treated by a Physician within 72 hours after the Covered Accident. We will pay only one benefit amount per Covered Accident.

Second degree burns which cover at least 36% of the body surface	$ 750
Third degree burns which cover at least nine square inches of the body surface but less than 35 square inches	$ 1,500
Third degree burns which cover 35 or more square inches of the body surface	$10,000

CATASTROPHIC ACCIDENT: The applicable benefit amount shown on the Policy Specification Page (Page 3) at the end of the elimination period if any Insured Person:
(1) sustains a Catastrophic Loss as the result of a Covered Accident;
(2) is under the appropriate care of a Physician during the elimination period; and
(3) remains alive at the end of the elimination period.

The Catastrophic Accident benefit will be payable once per lifetime for any Insured Person. This benefit reduces by 50% at age 70.

"Elimination Period" means the period of 365 days after the date of a Covered Accident.

CONCUSSION: $100 if any Insured Person sustains a concussion as the result of a Covered Accident and is diagnosed by a Physician within 72 hours from the date of the Covered Accident using any type of medical imaging procedure such as an X-ray, CT (computerized tomography) scan and/or MRI (magnetic resonance imaging). We will pay this amount once per Covered Accident. We will not pay the Concussion benefit if the Major Diagnostic Exams benefit is payable for the same Covered Accident.

DISLOCATION (SEPARATED JOINT): The applicable amount listed if any Insured Person receives a dislocation as the result of a Covered Accident. A dislocation is a completely separated joint. In order for this benefit to be payable for the joint involved, all of the following must occur:
(1) it must be diagnosed as a dislocation by a Physician within 90 days after the Covered Accident;
(2) the dislocation must require correction with anesthesia by a Physician; and
(3) it can be corrected by open (surgical) or closed (non-surgical) reduction.

If any Insured Person receives more than one dislocation in a Covered Accident, and requires open or closed reduction, We will pay for all dislocations. However, We will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a Physician, We will pay 25% of the amount listed for a closed reduction of the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay 25% of the amount listed for a closed reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

If any Insured Person receives a fracture and a dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

We will pay this benefit only for the first dislocation of a joint after the Policy Effective Date. Subsequent dislocations of the same joint after the Policy Effective Date will not be covered.

JOINT	**CLOSED REDUCTION**	**OPEN REDUCTION**
Hip	$4,000	$8,000
Knee (except Patella)	$2,000	$4,000
Ankle – Bone or Bones of the Foot (other than Toes)	$1,600	$3,200
Collarbone (Sternoclavicular)	$1,000	$2,000
Lower Jaw	$ 600	$1,200
Shoulder (Glenohumeral)	$ 600	$1,200
Elbow	$ 600	$1,200
Wrist	$ 600	$1,200
Bone or Bones of the Hand (other than Fingers)	$ 600	$1,200
Collarbone (Acromioclavicular and separation)	$ 200	$ 400
One Toe or Finger	$ 200	$ 400

All benefits increased

EMERGENCY DENTAL WORK: The applicable amount listed below for dental work required by any Insured Person as the result of injuries received in a Covered Accident.

Broken teeth repaired with crown(s) $150
Broken teeth resulting in extraction(s) $ 50
Benefits are payable only once per Covered Accident, regardless of the number of teeth involved.

EMERGENCY ROOM TREATMENT: $50 if any Insured Person is injured as the result of a Covered Accident and the Insured Person requires examination and treatment by a Physician in a Hospital Emergency Room within 72 hours after the Covered Accident. We will pay this amount once per Covered Accident. Benefit decreased.

Follow-up treatment prescribed by a Physician will be paid under the Accident Follow-Up Treatment benefit.

EYE INJURY: $200 if any Insured Person receives an eye Injury as the result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician within 90 days after the Covered Accident. We will pay this amount once per Covered Accident. An examination with anesthesia will not be considered surgery.

FRACTURE (BROKEN BONE): The applicable amount listed if any Insured Person receives a fracture as the result of a Covered Accident. A fracture is a break in a bone which can be seen by X-ray. In order for this benefit to be payable for the bone involved, all of the following must occur:

(1) it must be diagnosed as a fracture by a Physician within 90 days after the Covered Accident; and
(2) the fracture must require open (surgical) or closed (non-surgical) reduction by a Physician.

If any Insured Person receives more than one fracture in a Covered Accident, and he requires open or closed reduction, We will pay for all fractures. However, We will pay no more than two times the amount for the bone involved which has the highest benefit amount. If a Physician diagnoses the fracture as a chip fracture, We will pay 25% of the amount listed for the closed reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

If any Insured Person receives a fracture and a dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

FRACTURE (BROKEN BONE) Continued

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

BONE	CLOSED REDUCTION	OPEN REDUCTION
Skull (except Bones of Face or Nose) Depressed Skull Fracture	$5,000	$10,000
Skull (except Bones of Face or Nose) Simple Non-depressed Skull Fracture	$2,000	$4,000
Hip, Thigh (Femur)	$3,000	$6,000
Vertebrae, Body of (excluding Vertebral Processes)	$1,600	$3,200
Pelvis (includes Ilium, Ischium, Pubis, Acetabulum except Coccyx)	$1,600	$3,200
Leg (Tibia and/or Fibula)	$1,600	$3,200
Bones of Face or Nose (except Mandible or Maxilla)	$ 700	$1,400
Upper Jaw, Maxilla (except Alveolar Process)	$ 700	$1,400
Upper Arm between Elbow and Shoulder (Humerus)	$ 700	$1,400
Lower Jaw, Mandible (except Alveolar Process)	$ 600	$1,200
Shoulder Blade (Scapula), Collarbone (Clavicle, Sternum)	$ 600	$1,200
Vertebral Processes	$ 600	$1,200
Forearm (Radius and/or Ulna), Hand, Wrist (except Fingers)	$ 600	$1,200
Kneecap (Patella)	$ 600	$1,200
Foot (except Toes)	$ 600	$1,200
Ankle	$ 600	$1,200
Rib	$ 500	$1,000
Coccyx	$ 400	$ 800
Finger, Toe	$ 100	$ 200

All benefit amounts increased.

HOSPITAL ADMISSION: $1,000 per admission ($2,000 if immediately admitted to an Intensive Care Unit) if any Insured Person is Confined to a Hospital as the result of injuries received in a Covered Accident. The Insured Person must be Confined within six months after the Covered Accident. We will not pay this benefit for: benefit increased for ICU immediate admission

(1) Emergency Room treatment;
(2) outpatient treatment, or
(3) a stay of less than 20 hours in an Observation Unit.

We will pay this amount once per Covered Accident.

HOSPITAL CONFINEMENT: $250 per day for up to 365 days per Covered Accident if any Insured Person is Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit as the result of injuries received in a Covered Accident. The Insured Person must become Confined in a Hospital or a Hospital Sub-Acute Intensive Care Unit within six months after the Covered Accident. We will pay benefits for only one Hospital Confinement at a time even if it is caused by more than one Covered Accident.

We will not pay this benefit for:

(1) Emergency Room treatment;
(2) outpatient treatment, or
(3) a stay of less than 20 hours in an Observation Unit.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.

Number of days increased from 15

HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: $500 per day for up to 30 days per Covered Accident if any Insured Person is Confined to a Hospital Intensive Care Unit as the result of injuries received in a Covered Accident. The Confinement in a Hospital Intensive Care Unit must begin within 30 days after the Covered Accident.

If any Insured Person is Confined to a hospital intensive care unit that does not meet the definition in this Policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit. We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently. If any Insured Person is Confined in a Hospital Intensive Care Unit for more than 30 days, the Hospital Confinement benefit will begin on the 31st day. The total amount payable per Covered Accident will not exceed 365 days for Hospital Confinement and 30 days for Hospital Intensive Care Unit Confinement.

All Torn cartilage benefit are increased

KNEE CARTILAGE – TORN: $750 if any Insured Person receives a torn knee cartilage (meniscus) as the result of a Covered Accident. In order for this benefit to be payable, all of the following must occur:

(1) it must be treated by a Physician within 60 days after the Covered Accident; and

(2) it must be repaired through surgery by a Physician within six months after the Covered Accident.

If exploratory arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), We will pay a benefit of $150.

LACERATION: The applicable amount listed below if any Insured Person receives a laceration as the result of a Covered Accident. The laceration must be repaired by a Physician within 72 hours after the Covered Accident. The amount We will pay will be based on the total length of all lacerations received in any one Covered Accident which require repair. If the laceration is severe enough to require stitches but the Physician chooses to repair it in another way, We will pay it as a laceration repaired with stitches.

Laceration(s) treated without stitches, staples, glue	$ 25
Total of all lacerations is not more than three inches long (less than 7.6 centimeters) and repaired by stitches	$ 50
Total of all lacerations is greater than three and not more than five inches long (7.6 to 12.5 centimeters) and repaired by stitches	$200
Total of all lacerations is over five inches long (over 12.5 centimeters) and repaired by stitches	$400

If any Insured Person receives a laceration on a finger, toe, hand, foot, or eye and later loses that finger, toe, hand, foot or eye as the result of the same Covered Accident, We will subtract the amount We paid under the Laceration benefit from the Loss of Finger, Toe, Hand, Foot or Sight of an Eye benefit.

LODGING: $100 per night for one motel/hotel room for a companion to accompany any Insured Person for up to 30 days per Covered Accident. We will pay this benefit if any Insured Person is Confined in a Hospital as the result of a Covered Accident.

This benefit is payable only for motel/hotel stays during the period of time any Insured Person is Confined to the Hospital. In order for this benefit to be payable, the *hospital* must be more than 100 miles from the residence of the Insured Person.

LOSS OF FINGER, TOE, HAND, FOOT OR SIGHT OF AN EYE: The applicable amount listed below for any Insured Person for loss received as the result of a Covered Accident and which occurs within 90 days after the Covered Accident. All benefit amounts increased

Loss of both hands, or both feet, or the sight of both eyes, or any combination of two or more listed above	$30,000
Loss of one hand, or one foot, or sight of one eye	$15,000
Loss of two or more fingers, or two or more toes, or any combination of two or more listed above	$ 3,000
Loss of one finger or one toe	$ 1,500

"Loss of a hand" means that the hand is cut off through or above the wrist joint or the use of the hand is permanently lost. "Loss of a foot" means that the foot is cut off through or above the ankle joint or the use of the foot is permanently lost. "Loss of a finger" means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. "Loss of a toe" means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. "Loss of sight of an eye" means that at least 80% of vision is permanently lost.

If any Insured Person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same Covered Accident, We will subtract the amount We paid for that loss of a finger or toe from the benefit We paid for the loss of a hand or foot.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and Loss of Finger, Toe, Hand, Foot or Sight of an Eye result from the same Covered Accident, only the Accidental Death benefit will be paid.

MAJOR DIAGNOSTIC EXAMS: $150 per Calendar Year if any Insured Person requires one of the following exams for injuries received as the result of a Covered Accident:

(1) CT (computerized tomography) scan;
(2) MRI (magnetic resonance imaging); or
(3) EEG (electroencephalogram).

These exams must be performed in a Hospital, or a Physician's office.
We will not pay the Concussion benefit if the Major Diagnostic Exams benefit is payable for the same Covered Accident.

PHYSICAL THERAPY: $25 per day for each day any Insured Person requires physical therapy treatment as the result of a Covered Accident. We will pay a maximum of six days per Covered Accident. The therapy must begin within 60 days after the Covered Accident and must be completed within six months after the Covered Accident. All services must be prescribed by a Physician and rendered by a Physical Therapist and performed in an office or in a Hospital on an inpatient or outpatient basis.

This benefit is not payable for the same visit that the Accident Follow-Up Treatment benefit is paid.

PHYSICIAN'S OFFICE/URGENT CARE: $50 if any Insured Person receives initial treatment and/or advice by a Physician in a physician's office or Urgent Care Facility for injuries as the result of a Covered Accident. The treatment must be within 60 days of the Covered Accident and the services provided must be the result of a Covered Accident and not for routine examinations or preventive testing. We will pay this amount once per Covered Accident.
Follow-up treatment prescribed by a Physician will be paid under the Accident Follow-Up Treatment benefit.

PROSTHETIC DEVICE/ARTIFICIAL LIMB: The applicable amount listed below for a prosthetic device/artificial limb which is prescribed by a Physician for functional use when any Insured Person loses a hand, foot or sight of an eye due to a Covered Accident. The prosthetic device/artificial limb must be received within one year of the Covered Accident. We will pay this amount once per Covered Accident.

One prosthetic device or artificial limb	$ 500
More than one device or artificial limb	$1,000

We will not pay this benefit for:
(1) hearing aids;
(2) dental aids, including false teeth;
(3) eye glasses;
(4) cosmetic prosthesis such as hair wigs; or
(5) joint replacement such as an artificial hip or knee.

REHABILIATION UNIT: $150 per day if any insured person is confined in a Rehabilitation Unit for physical, occupational or speech therapy treatment of covered injuries. The rehabilitation unit confinement must be preceded by confinement in a hospital. This benefit is limited to a maximum of 30 days per insured person per accident. The Rehabilitation Unit benefit will not be paid if the Hospital Confinement Benefit is paid for the same day; only the highest eligible benefit will be paid. New benefit

RUPTURED DISC: $400 if any Insured Person receives a ruptured disc in his spine as the result of a Covered Accident. In order for this benefit to be payable, all of the following must occur:
(1) it must be treated by a Physician within 60 days after the Covered Accident; and
(2) it must be repaired through surgery by a Physician within one year after the Covered Accident.
We will pay this amount once per Covered Accident.

SKIN GRAFTS: We will pay 25% of the applicable Burn benefit if any Insured Person receives a skin graft for a burn for which a benefit was paid under the Burn benefit of this Policy. This benefit will be payable only once per Covered Accident.

SURGERY: $1,000 if any Insured Person undergoes open abdominal or thoracic surgery within 72 hours of the Covered Accident to repair internal injuries received as a result of a Covered Accident. For open abdominal or thoracic exploratory surgery without repair or other open abdominal or thoracic surgery without repair, We will pay a benefit of $100. We will pay this amount once per Covered Accident. Hernia repair will not be covered under this benefit.

TENDON/LIGAMENT/ROTATOR CUFF: The applicable amount listed below if any Insured Person receives an injured tendon/ligament/rotator cuff as the result of a Covered Accident. It must be torn, ruptured or severed. It must be repaired through surgery by a Physician within 90 days after the Covered Accident.

All benefit amounts increased

Repair of one tendon, ligament or rotator cuff	$600
Repair of more than one of the above	$900

If exploratory arthroscopic surgery is performed and no repair is done, We will pay a benefit of $150.

If any Insured Person receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament/rotator cuff in the same Covered Accident, We will pay only one benefit. We will pay the larger of either the Tendon/Ligament/Rotator Cuff benefit, the Fracture benefit or the Dislocation benefit.

TRANSPORTATION: $300 per round trip if any Insured Person must travel more than 100 miles round trip to receive special treatment and Confinement in a Hospital for injuries received as the result of a Covered Accident. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to three round trips per Covered Accident. This benefit is not payable for transportation by ambulance or air ambulance.

PART H HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after loss covered by this Policy occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received by Us at:

[Philadelphia American Life Insurance Company
Claims Administrator for Boston Mutual Life
P. O. Box 34952
Omaha NE 68134-9632]

or to Our Home Office in Canton, Massachusetts. It should include Your name and Policy number as shown on the Policy Specification Page (Page 3).

CLAIM FORMS: When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

PROOF OF LOSS: Written proof of loss, except for Catastrophic Accident, must be given to Us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PROOF OF LOSS FOR CATASTROPHIC ACCIDENT: Written proof of loss must be given to Us within 90 days after the Catastrophic Accident elimination period ends. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PART I TIME PAYMENT OF CLAIMS

Benefits for any loss covered by this Policy will be paid upon receipt by Us of proper written proof.

PART J PAYMENT OF CLAIMS

All benefits will be paid to You or Your estate. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

Any accidental death benefits payable as the result of Your death will be paid to Your beneficiary. Your beneficiary is the person You named in the application as Your beneficiary, unless it was changed at a later date. If You did not name a beneficiary or if the person You named is not living at Your death, any accidental death benefits due will be paid in this order to: (a) Your spouse; (b) Your children; (c) Your parents; (d) Your brothers or sisters; (e) Your estate.

PART K GENERAL INFORMATION

ENTIRE CONTRACT; CHANGES: This Policy is a legal contract between You and Us. The entire contract consists of the Policy, which includes the application, and any attached papers. No change in this Policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date a person becomes covered under this Policy We cannot use misstatements, except fraudulent misstatements, in Your application to void coverage or deny a claim for loss that happens after the two year period.

The above provisions also apply to riders attached to this Policy. In applying them the word "Rider" will be used for the word "Policy".

LEGAL ACTIONS: You cannot bring a legal action to recover benefits under Your Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

GRACE PERIOD: Your premium must be paid on or before the date it is due or during the 31 day grace period that follows. The Policy stays in force during Your Grace Period. This grace period does not apply if You request termination of this Policy.

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and We accept a premium without requiring an application for reinstatement, that payment shall reinstate this Policy. If We require an application, this Policy will be reinstated when We approve it. If We do not approve the application, this Policy will be reinstated on the 45th day after the date of the application unless We notify You in writing of its disapproval.
After two years from the date We reinstate this Policy, We cannot use misstatements in Your reinstatement application to void coverage or deny a claim for loss that happens after the two-year period. In all other respects You and We have the same rights under this Policy as We both had before it lapsed, unless special conditions are added to this Policy in connection with the reinstatement. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

MISSTATEMENT OF AGE: If the Insured's Age or sex has not been stated correctly, an adjustment in premium, coverage, or both, will be made. The adjustment will correct the coverage to what the premium paid would have bought at the Insured Person’s true Age and sex. This change will be based on our rates in effect on the Date of Issue.

OTHER INSURANCE WITH US: If You have more than one Accident Policy with Us, only one Policy chosen by You will be effective (this includes coverage for any Insured Person). We will cancel the Policy and refund all premiums paid for all other policies in force during the same period of time.

CHANGE OF BENEFICIARY: The beneficiary is named in the application or later endorsement as it applies to the Accidental Death benefit. The Primary Insured is the beneficiary for the spouse and children if these optional riders are included. You may change the beneficiary by written request without their consent. This change will take effect when We receive it. A payment by Us prior to receipt of such change will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have any Insured Person examined when and as often as is reasonable during the handling of a claim and do an autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at our expense.

TERM OF COVERAGE: Coverage starts on the Policy Effective Date at 11:59 p.m., Standard Time where You live. It ends at 12:01 a.m. on the same Standard Time on the renewal date, subject to the grace period. This Policy may be renewed only as stated in the Renewal Agreement. Each time this Policy is renewed, the new term begins when the old term ends.

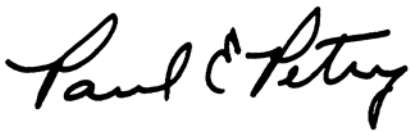
PART K GENERAL INFORMATION CONTINUED

CHARTER AND BY-LAWS: No provisions of Our charter and by-laws not included in this Policy shall void this Policy or be used in defense of any legal proceedings with regard to it.

NOTICE OF ANNUAL MEETING: You are welcome to come to Our Annual Meeting. It is held on the third Wednesday in April at three o'clock in the afternoon at Our Home Office in Canton, Massachusetts. You are entitled to one vote during the Annual Meeting.

POLICY SPECIFICATION PAGE: The Policy Specification Page (Page 3) and information it shows is a part of the Policy.

Signed for Us at Our Home Office on the Policy Effective Date.



President

Secretary

Summary of Enhancements to BML Accident Product

1. There will now two coverage options: (1) Off-the-Job only, and (2) 24-Hour Coverage. Previously (i.e. in the current version), we only had 24-hour coverage.

2. The Accidental Death Benefit will be increased.

    a. Insured:

        i. Regular Accident: Increased from $25,000 to $50,000 {New = 200% of Current}

        ii. Common Carrier: Increased from $50,000 to $100,000 {New = 200% of Current}

    b. Spouse:

        i. Regular Accident: Increased from $10,000 to $50,000 {New = 500% of Current}

        ii. Common Carrier: Increased from $20,000 to $100,000 {New = 500% of Current}

    c. Dependent Children:

        i. Regular Accident: Increased from $5,000 to $10,000 {New = 200% of Current}

        ii. Common Carrier: Increased from $10,000 to $20,000 {New = 200% of Current}

3. Catastrophic Accident Benefit: Spouse Benefit Increased to Equal that of Insured

    a. Insured: No Change

    b. Spouse:

        i. Prior to Age 70: Increased from $50,000 to $100,000 {New = 200% of Current}

        ii. Age 70 and After: Increased from $25,000 to $50,000 {New = 200% of Current}

    c. Dependent Children: No Change

4. Dislocation (Separated Joint): All of the Benefits are 200% of those in the current version.

5. Emergency Room Treatment: Benefit is reduced from $150 to $50.

6. Fracture (Broken Bone): All of the Benefits are 200% of those in the current version.

7. Hospital Admission:

    a. If immediately admitted to Intensive Care Unit, increase benefit from $1,000 to $2,000

8. Hospital Intensive Care Unit

    a. Maximum Benefit Period is increased from 15 days to 30 days per covered accident.

9. Knee Cartilage:

    a. All of the Benefits are 150% of those in the current version

    b. Torn Knee Cartilage: Increased from $500 to $750

    c. Exploratory Arthroscopic Surgery with No Repair Done: Increased from $100 to $150

10. Loss of Finger, Toe, Hand, Foot or Sight of an Eye:

    a. All of the Benefits are 200% of those in the current version.

11. Rehabilitation Unit:

    a. This is a new benefit.

    b. $150 per day, up to 30 days per covered person per accident.

    c. Rehabilitation unit confinement must be preceded by confinement in a hospital.

12. Tendon / Ligament / Rotator Cuff:

    a. All of the Benefits are 150% of those in the current version.

13. Wellness Benefit Rider

a. Current Version: Pays $50 once per calendar year **for only one Insured Person**

b. New Version: Pays $50 once per calendar year **per Covered Person**

14. Enhanced Emergency Room Benefit Rider

a. Current Version: Pays $100 per unit, up to 2 units. Maximum Emergency Room Coverage = $350 ($150 Base Policy + $200 Rider)

b. New Version: Pays $100 per unit, up to 5 units. Maximum Emergency Room Coverage = $550 ($50 Base Policy + $500 Rider).

15. Enhanced Physician Office or Urgent Care Treatment Rider

a. New Rider, not part of Current Accident Product

b. Pays an additional $25 per unit, if any covered person is injured as the result of a covered accident and the covered person requires examination and treatment by a physician in a physician's office or urgent care facility

c. Paid once per covered accident

d. Maximum Number of Units: 2 (i.e. Benefit = $25 or $50)

16. Occupational HIV Rider

a. New Rider, not part of Current Accident Product

b. Pays lump sum Benefit of $10,000 per unit for the initial positive diagnosis of Occupational HIV due to a Covered Injury

c. Maximum Number of Units: 5

    i. Maximum Number of Units will be limited until we get experience

d. Payable only once per Insured Person

e. Insured Person must be HIV negative prior to date of accident

f. Insured Person must have a preliminary screening test for HIV within 48 hours of the Injury, and must test HIV negative.

g. Insured Person must test HIV positive within 26 weeks of the date of the Injury

120 ROYALL STREET♦CANTON, MASSACHUSETTS 02021♦TEL. (800) 669-2668 ♦FAX (781) 770-0490

Peggy Schwartz, FLMI, ALHC, AIRC
Filing Manager

November 20, 2008 **VIA SERFF**

RE: NAIC # 61476 – FEIN # 04-1106240
Boston Mutual Life Insurance Company
Individual Accident Only Policy et al

Accident Policy:	WS-ACC 8/08
Outline of Coverage	WSACCP-OC 08/08
Spouse Accident Rider	SpAcc Rider 8/08
Dependent Children Accident Rider	CA-Rider 8/08
Enhanced Physician Office/Urgent Care Rider	EPO-Rider 8/08
Enhanced Emergency Room Benefit Rider	EER-Rider 8/08
Wellness Benefit Rider	WB-Rider 8/08
Occupational HIV Benefit Rider	OHIV-Rider 8/08
Sickness-Hospital Confinement Benefit Rider	SH-Rider 8/08
Application (hard copy/lap top version)	WSA-P 8/08
Application (print-out of lap top screen)	WSA-E 8/08

Company Tracking # IND-08-005

Enclosed for your approval is a filing package for accident policy form WS-ACC 8/08 and its supporting documents. This policy package is substantially similar to and replaces policy package WIND-ACC 11/05 which was approved in your jurisdiction. A list showing the approval information for the replaced policy for each jurisdiction as well as a marked sample policy and a summary of the upgrades and/or changes is included in this filing.

The policy is an individual accident only product. Benefits are detailed in the policy and outlined in the Outline of Coverage. This individual policy is marketed in the employer/employee salary deduction market and the employer chooses the benefits that will be offered at that worksite. They may choose either a full accident coverage policy or a non-occupational accident coverage policy to limit over-insurance in occupational accident coverage due to worker's compensation coverage.

Seven optional riders are included in the filing for use with this policy:

SpAcc Rider 8/08 will be issued if the applicant elects coverage for a spouse.
CA-Rider 8/08 will be issued if the applicant elects coverage for a dependent child.
EPO-Rider 8/08 provides additional coverage for treatment of a covered accident in a physician's office.
EER-Rider 8/08 provides additional coverage for treatment of a covered accident in the emergency room.
WB-Rider 8/08 provides a flat benefit for certain health screening tests performed by a physician.
OHIV-Rider 8/08 provides an additional benefit if the insured person tests positive for HIV as the result of accidental exposure during the course of their occupation.
SH-Rider 8/08 provides a daily benefit amount if the insured person is confined to a hospital as the result of a covered sickness.

Coverage will be applied for using the application included in this filing. We are submitting two application versions for review. One (WSApp-P 8/08) is the hard copy/lap top version. This is the only version which is used during enrollment. This policy can be applied for at the applicant's worksite using an electronic lap top application. The information from the lap top application is given a unique security code and stored and transmitted to the home office on disk. When this electronic enrollment is processed, application (WSApp-E 8/08) is the print-out version of the application. This print-out of the electronic enrollment application is attached to the issued contract and stored

in the company's files. A complete description of the electronic enrollment process is included under supporting documentation.

This accident coverage will be marketed through licensed agents and brokers in the general individual employer/employee worksite salary deduction market. These forms do not contain any unusual or controversial items from normal company standards and are in compliance with the laws and regulations of your state.

The forms are written in readable language that meets your minimum Flesch score requirements. A certification of readability is enclosed in this filing.

These forms have been filed concurrently in our state of domicile, Massachusetts.

Please contact me if you need further information.

Sincerely

Peggy Schwartz, FLMI, ALHC, AIRC
(800) 669-2668 Ext. 423
Fax: (781) 770-0490
marguerite_schwartz@bostonmutual.com